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Community Control of Health Financing in India: A Review of Local Experiences

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PHR

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Abstract

This study, which aims to gain information on community-controlled health financing in India, is commissioned by the United States Agency for International Development/India to inform the planning of the Women's and Children's Health (WACH) Project. The study consists of a review of the literature and five mini case studies. The literature review examines 10 instances of community financing, which indicate that community involvement in designing financing strategies resulted in more appropriate strategies. The five case studies suggest a link between community control and improvements in quality of care, equity and efficiency, and financial soundness. It was found that community-controlled financing is fairly widespread in India and, when established and supported correctly, can have a positive impact on health programs and lead to greater financial and institutional sustainability. Establishing community-controlled health financing under the WACH Project is recommended. Taking into consideration factors that can influence success, the following recommendations are made: support a variety of community financing models; provide inputs for building capacity; ensure that development needs, apart from health, are being met; involve local communities from the beginning; provide support to establish community financing; promote links with other local groups; and ensure access to technical and other expertise.

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Acronyms

AKHS	Aga Khan Health Services
AWARE	Action for Welfare and Awakening in Rural Environment
BSA	Banwasi Sewa Ashram
HSMC	Health Sector Management Committee
MCH	Maternal and Child Health
NGO	Non-governmental Organization
PHC	Primary Health Care
PHR	Partnerships for Health Reform
PRI	*Panchayati Raj* Institution
RMS	Rangabelia *Mahila Samiti*
RUHSA	Rural Unit for Health and Social Affairs
UMBVSP	Urmul *Marusthali Bunker Vikas Samiti*, Phalodi
USAID	United States Agency for International Development
VHS	Voluntary Health Service
WACH	Women's and Children's Health Project
ZMC	Zonal Management Committee

Preface

This study was undertaken as part of the Partnerships for Health Reform (PHR) Project's contribution to Phase I of USAID/New Delhi's Women's and Children's Health (WACH) Project. WACH was designed to take place in the state of Madhya Pradesh, with the objective of reducing neonatal mortality through delivery of an essential package of maternal and child health services to be provided at the community level, with funds provided directly to the communities. Although the WACH project did not progress beyond Phase I due to lack of agreement on implementation arrangements between USAID/New Delhi and the Government of Madhya Pradesh, this study on community control of health financing can contribute to related work in India and elsewhere.

This review of experiences in community control of health financing in India was designed by Nancy Pielemeier and Denise DeRoeck of PHR, to derive lessons from previous experiences in India on community control of health financing, a concept that is much discussed but little documented. The literature review is based on written documentation of experiences and is supplemented by "mini-case studies," based on brief visits to sites with collection of information through interviews and limited review of administrative documents available on site. The study reveals that while community control of health financing is considered widespread, experience with this form of administration is quite limited in India as a whole, and has not yet even been tried in Madhya Pradesh in particular. The literature review, management of the case studies, and completion of some of the studies was carried out with great care and attention to detail by PHR consultant Priti Dave Sen. Dr. Barun Kanjilal, Dr. Suneeta Sharma, and staff of PHR's local subcontractor, the Indian Institute for Health Management Research in Jaipur, carried out selected case studies and made it possible to complete this review in an efficient and effective manner. Rekha Masilamani and Rajani Ved of USAID/New Delhi provided inspiration and support throughout. We hope that they will benefit from the findings in future projects benefiting the people of India.

Acknowledgments

Grateful thanks to the five organizations that kindly agreed to participate in the study and gave their full cooperation and assistance. The work undertaken by the Indian Institute for Health Management Research in Jaipur is fully acknowledged. Finally, thanks is extended to the United States Agency for International Development office in New Delhi for the support given during the field visits.

Executive Summary

Background

This study represents one of several commissioned by the United States Agency for International Development/India to inform the planning of the Women's and Children's Health (WACH) Project. The study aims to gain information on whether or not true community-controlled health financing exists in India and how these experiments have worked. The study consists of two parts: (1) a review of the available literature on community-controlled health financing in India and (2) several mini case studies that illustrate how experiments in community-controlled health financing have worked.

Community control of financing is defined as any source of finance (such as user fees, government grants, or donor funds) that is at least partially in control of local communities. Control is viewed as a continuum. At one end, communities may have no power whatsoever to either receive funds or influence how funds are spent for health improvements. At the other end, local communities may have the power to raise, manage, and spend health funds. Included in this study is a matrix of financing functions that was developed to access community control of health financing in the literature and in the case study examples.

Different criteria of local control of financing were used for selecting the literature review and case study examples. To be included in the literature review, communities needed to have at least some say regarding the planning, management, or implementation of health financing strategies. For the case studies, communities were required to be able to receive funds (either directly or indirectly), have some financial responsibilities, as well as have some say on how the funds were to be spent. In addition, there needed to be a visible local structure, which represents the community and through which local control is being exercised.

Study Findings

1. Literature Review

Ten examples of community-controlled health financing were selected from the literature. Of these, eight are in the non-profit, non-government sector (i.e., non-governmental organizations [NGOs]), one is a tertiary-level government hospital, and one is a registered district health committee (chaired by the district collector and chief medical officer). The degree and scope of community control of health financing vary enormously across the NGOs and government bodies. In the narrowest sense—in the NGO examples—local communities are responsible for collecting financial contributions (usually contributions toward a pre-payment scheme) on behalf of NGOs. In some cases, they are responsible for deciding who should be exempt or pay less for health services. Some NGOs involve communities in project planning, including planning financing strategies. One NGO,

Action for Welfare and Awakening in Rural Environment (AWARE) in Andhra Pradesh, hands over control to local communities in a phased manner and withdraws completely once sufficient capacity has been developed. This organization claims to have created 380 autonomous, self-reliant community organizations. NGOs tend to have more experience in the local management of funds for income-generating activities, such as disbursing loans for various economic activities. The government hospital has control of revenue generated from user fees, and the autonomous district society currently controls funds from donors.

In all cases, a community structure was used to facilitate local control. Some organizations used existing structures, such as *mahila mandals* (women's groups) or milk societies; others set up special structures such as village or district health committees. The reasons for initiating local control vary considerably. In the case of the government hospital, it was in response to chronic shortages of cash for non-salary recurrent expenses and as a means of by-passing government regulations that do not allow health facilities to retain revenue raised through user fees.

The NGOs and government hospitals tap a number of community financing sources. These include user fees, pre-payment schemes, in-kind contributions, and local donations. Many of them successfully address equity concerns by waiving or reducing fees for those considered unable to pay. In some cases, community-generated revenue represents a significant proportion of total funds.

The impact of community control of health financing was difficult to discern from the literature. In the case of the government hospital, it definitely led to improvements in the quality of care, since revenue generated from user fees was used to purchase new equipment and to maintain the building. Community involvement in the design of financing strategies resulted in more appropriate strategies, especially those involving exemption schemes.

2. Case Studies

Five mini case studies were conducted to examine in detail experiences with community control of health financing. In the five communities studied, the local structures used to facilitate local control include a cooperative health committee (Mallur Health Cooperative), a society-based committee together with women's groups and other village-based bodies (UMBVSP), a council together with a network of village-based organizations (Rangabelia *Mahila Samiti*), management committees (Aga Khan Health Services), and *panchayati raj* institutions (PRIs) (locally elected bodies). The legal status of the local institutions varied, and this influenced their ability to receive funds, as well as their scope of financial control. The local groups vary in their composition (in terms of caste, class, and gender), how they are selected (by nomination or vote), the length of their tenure, and how they function and make decisions.

Three of the local institutions (PRIs, UMBVSP, and Mallur Health Cooperative) are able to receive funds directly from either the community, the government, or donors. Funds for the other two local bodies (Rangabelia *Mahila Samiti* and Aga Khan Health Services sector committees) have to be channeled through an NGO. In terms of their ability to spend funds, some local institutions are able to determine their own spending priorities and allocate resources accordingly (in some cases for specific funding sources only). Others have to allocate against pre-determined or pre-agreed–upon expenditures. Concerning other financing responsibilities, all local groups to an extent are involved in planning health activities and financing strategies. PRIs in Kerala have been involved in planning under the state's new five-year plan, and will be responsible for spending 40 percent of all allocations. In another case study example, local communities are responsible for drawing up an annual plan and budget. There are also experiences of local communities undertaking means testing.

Other responsibilities held by the local groups include setting fee levels, the management of day-to-day health services, sanctioning repairs for buildings, and purchasing drugs. Only three of the five communities operate a bank account.

A tentative link can be made between community control and improvements in the quality of care, equity and efficiency, and financial soundness. PRIs use funds generated from local taxes to supplement government funds. Typically, tax revenue has been spent on capital expenditure items, such as construction and maintenance, and the purchase of equipment. Community involvement in designing exemption schemes and identifying the poor (in the cases of Aga Khan Health Services and the Mallur Health Cooperative) has reportedly resulted in greater equity of health provision.

Factors Affecting the Success or Failure of Community-Controlled Health Financing

A number of factors appear to influence the success of community control of health financing:

1. The Technical and Institutional Capacity of the Local Group

Technical strength includes knowledge of health-related matters (or ability to access this knowledge), as well as skills in management and finance. Institutional strength includes such aspects as whether local groups are representative of the community they serve (i.e., group members reflect caste, class, and religious affiliations) to ensure that needs of all sectors of the community are met. It also includes aspects of good governance such as how members are selected, their tenure, how decisions are made, and mechanisms of accountability.

Only one of the local institutions (Mallur Health Cooperative) had in-house technical capacity, while others were able to access technical support from NGOs. None had received training in management and finance. In some cases, this seriously affected their ability to undertake their financing responsibilities.

Domination by one religious group in the local structure of one of the organizations studied (Aga Khan Health Services) appears to have influenced utilization by other sectors of the community. Utilization by non-Ismailis is lower than that of Ismailis in relation to their numbers in the community. It seems likely that the community perceives the organization to be run by Ismailis primarily for Ismailis.

Group dynamics and the degree to which members have an equal voice influence the functioning of local institutions. However, in the majority of cases, one or two members tend to dominate, especially those who are better educated and from higher castes. Those local institutions that are autonomous registered bodies tend to have better mechanisms for maintaining accountability to the community. These mechanisms include holding annual public meetings, publishing annual reports, and notifying the public of costs of planned construction or maintenance work.

2. Financial Control as Part of a Broader Strategy in Local Management and Control of Health Care Services

The evidence suggests that financial control in the absence of broader management responsibilities will be ineffective in the long run. Financial devolution has to be accompanied by devolution of planning, management, and administrative responsibilities. In many of the examples of community-controlled health financing, financial and other management responsibilities were or are being devolved gradually as local capacity is strengthened.

3. Support Received from Outside Organizations and Individuals

The ability of local institutions to tap external support—both technical expertise and funding—on an ongoing basis seems to affect their success. This is true in the case of the Mallur Health Cooperative, which is able to access technical advice from the St. Johns Medical College. Insufficient attention has been given to the establishment of ongoing support to local institutions in cases where support is gradually being withdrawn with the objective of withdrawing completely (AWARE and Aga Khan Health Services).

4. Links with Other Local Organizations

It is important that the local groups maintain contact with other local organizations, such as *panchayats, mahila mandals*, and the district health administration. This both enhances their status and standing in the community and leads to more efficient operations. For example, the Mallur Health Cooperative coordinates with the local government primary health center for child immunization, ante-natal care, and family planning. Coordination also leads to a more integrated effort in development, for example, if a local group that is active only in the health sector coordinates with one working in education.

5. Diversity of Funding, Including Community Financing

Local groups that have access to multiple sources of funding rather than relying on one source naturally tend to be more financially secure. The source and type of funding also affects financial strength (i.e., some sources are more stable and reliable while others may afford greater flexibility of use). For example, community-generated funds are generally more flexible since they can be used at the discretion of the local groups to meet local priorities.

6. Responding to Other (Non-Health) Development Needs of the Community

A community group may not have local credibility if it addresses health needs before other development needs, either directly by them or by another organization. Typically, communities tend to view health as a lower priority than economic development. Three of the groups in the case studies (UMBVSP, Mallur Health Cooperative, and Rangabelia *Mahila Samiti*) and many of the NGO examples included in the literature review addressed economic needs before health and other social needs.

7. Ability to Adapt to a Changing Environment

A local group needs to be able to adapt both in programmatic and management terms as the environment changes. For example, the Mallur Health Cooperative set up different local management structures as the organizations diversified their economic and social activities. Also, different financing strategies may have to be adopted over time as the funding environment changes. In the case of Mallur, financing evolved from the use of tax revenues on the sale of milk to user fees and interest from an endowment.

Implications of Study Findings for the WACH Project

This study shows that community control of health financing is fairly widespread in India. However, the scope of control and the capacity of local institutions to undertake their tasks vary enormously. The study suggests that when established and supported correctly, community-controlled financing can have a positive impact on the quality of care, equity, efficiency, and financial soundness of health programs. It can also lead to greater financial and institutional sustainability.

It is recommended that community-controlled health financing be established under the WACH Project. However, valuable lessons should be drawn from the study experiences as to how and how not to go about establishing community control. Taking into consideration the factors that appear to influence the success of community-controlled financing, the following recommendations are made:

1. Support a Number of Different Models of Community-Controlled Health Financing

It may be best to use a number of different community structures, each having different financing powers. Either existing community structures could be used (such as *mahila mandals*, economic cooperatives, PRIs, etc.) or a new structure could be created, such as a village health committee or society. This would depend on the presence of local groups and if it would be appropriate for them to take on further responsibilities.

PRIs are one of the best options for promoting community control, since they are legal bodies that already have significant power. However, their strength in Madhya Pradesh is unknown. Their capacity in the state would have to be assessed, and the feasibility of supporting them investigated.

2. Provide Inputs to Build Capacity of Local Institutions

Significant inputs should be provided to strengthen technical and institutional capacity of local institutions. This should include development of skills in health and management, including financial management. Institutional strengthening includes helping to promote and establish good governance, such as ensuring that procedures are fair for selecting members and that mechanisms are in place to ensure local accountability (e.g., regular publication of proceedings and general meetings to which the public is invited). Institutional strengthening will also require support that is more qualitative in nature, such as efforts to support team building and promotion of good group dynamics.

Institutional strengthening would need to be an ongoing process. Community control should be viewed as a continuum, with authority being handed over in a phased manner as local groups gain strength.

3. Ensure That Other Development Needs Apart from Health Are Being Met

Before introducing community-controlled health financing under the WACH Project, an assessment should be undertaken as to whether other development needs, apart from health, are being met. If they are not, it may be difficult to establish community control of health financing by the community since health is generally perceived as a relatively lower priority.

4. Involve Local Communities in the Project from the Beginning

Local communities should be involved in project planning, including the design of financing strategies. This will increase their commitment to community control.

5. Provide Support to the Establishment of Community Financing

Community financing—that is, the generation of local funds through user charges, pre-payment, or revolving drug schemes—appears to be an important aspect of community-controlled health financing. The literature and case study examples have shown that significant resources can be raised in this way, which can strengthen the financial status of the organization, while still protecting the poor through means testing methods. Moreover, such funds also represent a more flexible funding source, since they can be used directly to meet priorities determined by the community itself.

6. Promote Links between the Local Institutions and Other Local Groups

The project should ensure that the local institutions involved forge links with other community groups, as well as with local government health services, so that health and other social services in a particular locality are developed in a coordinated manner.

7. Ensure That the Local Institutions Have Access to Technical and Other Expertise on an Ongoing Basis

This support will be critical to the success of community-controlled health financing and should be available, as needed, over the long term. It can be provided by NGOs, academic institutions, donors, and others.

1. Background and Methodology

1.1 Background, Aims, and Objectives of the Study

The United States Agency for International Development (USAID)/New Delhi has developed a community-based primary health care (PHC) project, the Women's and Children's Health (WACH) Project, to focus on improving maternal and child health (MCH), particularly neonatal health, in the Bhopal Division of Madhya Pradesh. The project is currently in the design phase. This study represents one of several requested by USAID/New Delhi to inform the design of WACH Project activities. The purpose of the study is to gain information on whether or not true community-controlled health financing exists in India, and how these experiments have worked. The study consists of two parts:

- a review of the available literature on examples of community control of health financing in India, including experiences with user fees, social insurance and government and private contributions, and

- several mini case studies of experiments in community control of health financing.

The literature review and case studies aim to illustrate how experiments in local control of health financing have worked, and the factors that affect their success or failure. The findings of this study will help inform the design and implementation of health financing activities under the WACH Project.

1.2 Definition of Community Control of Health Financing

Since the aim of the study is to review experiences with community control of health financing, an attempt was first made to define the term and set the parameters for the literature review and case studies. A distinction is made between community-generated health financing and community *control* of health financing. The former usually refers to funds raised directly from clients or communities and that are retained and used locally for health services. It includes user fees, pre-payment/insurance schemes, local donations and so forth. On the other hand, community *control* of health financing is defined here in broader terms—to include any source of health financing that is at least partially controlled by local communities. Sources of financing under the community's control can include community-generated financing (described above), as well as government grants, revenue from income-generating activities, and external donations. Community-generated health financing is therefore a sub-set, or one type of community control of financing. This study focuses primarily on community control.

Community control is viewed as a continuum. At one end, communities have no power whatsoever to either raise, manage or spend health funds, and at the other end, local communities have total control over the raising, management, and allocation of health funds. In between this, there is a range of different degrees and types of financial responsibilities and authority. For example, local communities may:

- be able to raise local revenue but are not able to retain revenue for local health improvements;
- have control of community-generated finance, but not control of other financing sources;
- not have the power to operate a bank account but may still have considerable financial responsibilities, such as setting user fee levels, paying bills and deciding who should be exempt from user charges.

These are clearly increasing degrees of control. Another way of examining the concept of local control is by the degree of influence communities wield in making health financing decisions. This discussion draws heavily from the theory of community participation and development, which describes the interaction and relationship between external organizations or individuals and local people (British Department for International Development internal document, 1995). Again, it can be viewed as a continuum. At one end, communities may merely be consulted on financing issues (for example, during the design of financing strategies or in the setting of spending priorities), but their views may not necessarily influence the final decisions. Alternatively, decisions may be made jointly by external institutions and the communities. This is usually through a process of debate and consensus, or sometimes in a more formal manner by asking communities to rank in order of preference a number of financing options (PRICOR, 1987). At the other end of the spectrum, communities may have sole decision-making power. They may still maintain contact with external institutions for resources and technical advice, but retain control over how resources are used. In this study, local control is defined as having, at a minimum, joint decision-making powers.

A matrix outlining different aspects of health financing is shown in Figure 1-1, which has been adapted from a matrix developed by Tom Bossert on decentralization and local decision making (Bossert, 1997). The matrix is used to examine the types of financing responsibilities in the control of local communities for the literature and case study examples. The matrix divides community control of health financing into three aspects. The first is the ability of communities to receive funds, either from certain sources only, such as community contributions or government grants, or from any source. The second aspect is the communities' ability to allocate resources. This ability can range from no authority to the ability to allocate funds against pre-determined expenditure items only (e.g., those defined by a non-governmental organization [NGO]), to the ability to determine spending priorities. They can also have control over the allocation of all funds, or only those generated by certain sources, such as user fees or insurance schemes. The final area of control involves other financing responsibilities held by communities. These include whether they were involved in the design of the financing strategy, their involvement in the administration of exemption schemes, their involvement in annual or longer term planning and budgeting, whether they operate a bank account, and financial reporting and monitoring responsibilities that they have.

1.3 Study Methodology and Sources of Information

An Indian organization (the Indian Institute of Health Management Research (IIHMR), based in Jaipur, was contracted to help with the literature search, as well as undertake two of the mini case studies. Both published, and where accessible, unpublished literature were reviewed. Sources of unpublished literature included annual reports of NGOs and progress reports of donor organizations. Examples for the case studies were identified through a literature search and

No Control

Maximum Control

Figure 1-1
Matrix of Community Control of Health Financing

Ability to Receive Funds	Ability to Spend Funds	Other Financing Responsibilities
	No power	Design of health program and financing strategies ▲ Select financing strategy ▲ Set free/premium levels ▲ Design exemption schemes
Community contributions only	Can allocate against preset expenditure items only	Annual (or longer) planning and budgeting Administration of exemption schemes
Other sources as well All sources	Can define own spending priorities	Operate bank account Financial reporting and monitoring

Source: Adapted from Bossert, Thomas. 1997. *Decentralization of Health Systems: Decision Space, Innovation, and Performance*. Boston: Data for Decision Making Project

through discussions with a number of donor organizations, NGOs, and research institutes in India. The final case study examples were selected to represent a range of different types of local bodies exercising varying degrees of control of health financing.

In anticipation of the difficulties in examining aspects of community control in the existing literature, different criteria were applied for selecting the literature and case study examples. To be included in the literature review, communities needed to have at least some ability to raise, manage or spend health funds. For the case studies, a more rigorous criteria on financial control was used. Communities had to be able to receive funds; have some financial responsibilities, either administrative or management (e.g., payment of bills, setting fee levels, or exempting the poor); and have some say on how to spend funds, such as for purchasing equipment, building maintenance, etc. In addition, there needed to be an identifiable local structure or body representing the community, such as a village committee, hospital board, or cooperative society, through which financial control could be exercised.

The term *community* is used here in a geographic sense, as a group of households residing in a defined area. This may or may not coincide with administrative units established by the Indian government, such as village, block, and district. In most of the examples, the community is no larger than a block, which on average represents approximately 100,000 people. This is with the exception of the two government hospitals selected from the literature, in which the term community covers a larger area.

For both the literature and case study examples, the following information was collected and analyzed (see Annex A for the study guidelines). First, general background information was collected, such as the constituency served and the health and other social services provided. Some background information was also collected on when and by whom local control was initiated. Second, information was collected on the local body representing and exercising control on behalf of the community, including the composition of the body, the rules and regulations governing it and, where possible, the way in which decisions are made. Next, sources and levels of funding were analyzed,

including community-generated finance. Financing control exercised by the local communities was assessed against the matrix of financing functions shown in Figure 1-1. Finally, an attempt was made to assess the success or relative impact of community control in terms of equity, quality of care, efficiency and financial soundness.

For the case studies, three days were spent at each of the sites. The researchers held meetings with members of the local institutions and, where relevant, the supporting institutions as well. The researchers visited health facilities and held discussions with the health staff. Where available, secondary source materials were also reviewed, including annual reports and other project documents.

1.4 Limitations of the Study

The researchers found an overall lack of published literature on community-controlled health financing and, where it exists, relevant information is often lacking. More information exists on local control of other program aspects (i.e., non-financial), such as the selection of health facility sites and involvement in staff supervision. There is also considerably more information available on community-generated financing than on community-controlled health financing; only a few examples in the literature lend themselves to analysis of aspects of community control. Therefore, for the examples drawn from the literature, the questions listed in the study guidelines (Annex A) could not always be answered but were addressed as well as they could be.

In contrast, the mini case studies, which involved field visits, allowed for a more in-depth examination of local control of health financing. However, since only three days were spent at each site, time was a serious constraint. It was especially difficult to analyze the actual impact or success of community control in the time available. Conclusions regarding the impact of these experiments are based largely on impressions elicited from members of the local institutions or support organizations and from health staff, and are therefore rather tentative. Time did not permit interviews to be conducted with patients or with the wider community.

1.5 Structure of the Report

The next section summarizes experiences in community control of health financing in India drawn from both the literature search and the mini case studies. For all examples the following issues are examined: the types of health services provided and the target population, sources of funding, the types and scope of financing power held by local communities (assessed against the matrix in Figure 1-1), the means by which this power is exercised, how local control was initiated and, to the extent possible, the impact of community financing control in terms of improvements in quality, equity and financial soundness. Since community-generated financing is an important aspect of community-controlled health financing, this is also examined in-depth.

Based on study findings, Section 3 attempts to extrapolate the factors that affect the success or failure of community-controlled health financing. Implications of the study findings and lessons learned for the WACH Project are discussed in Section 4.

2. Literature Review of Community-Controlled Financing Experiences

2.1 Selection of Examples from the Literature

Most of the experience with community control of health financing in India—or at least that which is documented—has been in the not-for-profit private sector, initiated and supported by NGOs. Community control appears to be fairly widespread, but the degree and types of community control vary enormously across organizations. At its simplest, it involves local responsibility for collection of financial contributions from community members or, in one case, community management of a pre-payment fund. Eight examples from the NGO sector have been selected from the literature. These are: Sewagram, Goalpara Cooperative Health Society, Tribhovandas Foundation, Banwasi Sewa Ashram (BSA), Child in Need Institute, Rural Unit for Health and Social Affairs (RUHSA), Voluntary Health Service (VHS), and Action for Welfare and Awakening in Rural Environment (AWARE).

Two examples of local control in the government sector have also been selected, both providing hospital-based care. These are the West Bengal district hospitals, and the SMS Hospital in Jaipur, which provides tertiary-level care.

Below we summarize these 10 experiments in local health financing control, particularly the funding sources, scope of local financial control and—where the literature permits—the means by which local control is exercised. The main characteristics of these experiments are summarized in Table 2-1. The references for these examples are provided in the Bibliography of this report.

2.2 Type of Organizations, Services Provided, and Sources of Funding

As shown in Table 2-1, the eight NGOs included in the literature review vary in their location, size (as indicated both by the population they serve and their total annual budget), the types of services they provide and their sources of funding. All serve mainly rural constituencies. Some, like BSA and AWARE, serve predominately tribal populations. The size of their catchment population varies from 1,247 to 975,000.

Five NGOs (Tribhovandas Foundation, BSA, Child in Need Institute, RUHSA, and AWARE) provide health care as part of an integrated development effort. Non-health activities include agricultural extension, credit and income generation, and education. In some cases, like Child in Need Institute and RUHSA, the NGO began as a health provider only, but upon recognizing the low priority communities accorded health in relation to their other development needs, they subsequently broadened the scope of their activities.

Table 2-1
Summary of Main Characteristics of Examples of Community-Controlled Health Financing Selected from the Literature Review

Name	Status	Location	Population Served	Health and Other Services Provided	Total Annual Budget (rupees)	Sources of Funding (percentage)	Local Community Structure
Sewagram	NGO	Rural Maharashtra	19,457	500-bed hospital outreach community health program	69,459 (1989)	Pre-payment (96%) Other (4%)	Village health committee
Goalpara	NGO	Rural West Bengal	1,247	Dispensary outreach care on ad-hoc basis	32,000 (1989)	User fees, pre-payment, fund raising, in-kind donations	Village health committee
Tribhovandas Foundation	NGO	Rural Gujarat	800,000	Integrated rural development health: community-based health program; nutritional rehabilitation	10,800,000 (1989) (all activities)	Government; user fees; pre-payment; donor	Milk societies
Banwasi Sewa Ashram (BSA)	NGO	Rural, tribal Uttar Pradesh	350,000	Integrated rural development health: community health workers, health posts, and clinics	5 million (1986) (all activities)	50% self-generated; income generation activities; and *gram kosh* (village fund)	People's committees
Child in Need Institute	NGO	Rural West Bengal	80,000	Community development health: MCH (including nutritional rehabilitation)	10 million (1988) (all activities)	Government; donors; user fees (5%)	*Mahila Mandals* (Women's groups)
Rural Unit for Health and Social Affairs (RUHSA)	NGO	Rural Tamil Nadu	100,000	Integrated development health: community health workers, mobile health centers	3,500,000 (1986)	Donors; government; user fees (12%)	RUHSA Society and Village Advisory Committee
Voluntary Health Services (VHS)	NGO	Rural/peri urban Tamil Nadu	160,000	220-bed hospital community: health centers and outreach workers	Hospital: 1,983,920 community: 5,840,816 (1988)	Pre-payment scheme; user fees; donors; government	Local Action Committees
Action for Welfare and Awakening in Rural Environment (AWARE)	NGO	Rural Andhra Pradesh (tribal)	975,000	Integrated development health: hospital, health centers, mobile	40 million (all activities) (1998)	Donor loan; government; income generation; revolving fund	Village organizations
SMS Hospital, Jaipur	Government	Urban Rajasthan	——	1,300-bed hospital	110 million (1996)	Government; user fees (Rs. 18.2 million)	Hospital Society Committee
District Hospitals, West Bengal	Government	Rural and urban West Bengal	——	District level hospitals	——	Government; user fees; donations	Hospital Society Committees

The NGOs also vary enormously in terms of the health services they provide. Some, like Tribhovandas Foundation, offer only community-based care, and others, like Goalpara, operate a dispensary that provides care on an outpatient basis only. However, the majority provide three levels of health services. The first level consists of community health workers, who provide mainly preventive and promotive care. The second level usually comprises a health facility, such as a health post, health center or clinic where outpatient curative services are provided, as well as support to the community-based program. This level usually has a qualified medical practitioner in attendance, either part-time or full-time. In some cases (RUHSA, Sewagram, and AWARE), community care is supported by a mobile medical team, instead of or in addition to the health center. The third level of services consists of hospital care. The number of beds and level of specialist care vary considerably between the organizations. For example, Sewagram runs a 500-bed hospital and VHS has 220 beds. Two of the organizations (Child in Need Institute and Tribhovandas Foundation) run a nutrition rehabilitation center.

The varying size and scope of activities of the organizations is reflected in the enormous range in their annual operating budgets, which ranged from 32,000 to 40 million rupees (Rs.) in the late 1980s.[1] It was not always possible to separate health costs from the costs of other activities. As a result, these figures are not directly comparable. For example, AWARE's Rs. 40 million budget represents the costs of all of its activities combined, while Goalpara's budget of Rs. 1,247 is for health services only.

The two government examples selected consist of a 1,300-bed hospital in Jaipur (the state capital of Rajasthan), and district-level hospitals in the state of West Bengal. The former, the SMS Hospital, is a highly specialized, tertiary-level facility, which is also a teaching hospital. Its annual budget is Rs. 110 million. District hospitals in West Bengal are secondary-level hospitals, which, in most cases, provide the main specialty services, such as obstetrics, gynecology, and pediatrics. The population of a district in West Bengal can range from 500,000 to 1,500,000.

The NGOs tap an array of funding sources. These include: user fees, pre-payment schemes, government grants (both central and state), donations from both international and indigenous donors), in-kind contributions from communities and income-generating activities. Community-generated financing sources—user fees, pre-payment, in-kind donations and local fund raising—are examined in more detail in Section 2.6.1. The proportion of total funds that are generated from community sources can be determined for some of the NGOs. Community-generated funds represent 96 percent of total funds of the community-based health project at Sewagram, 12 percent of total funds at VHS and five percent at BSA. Government grants may be limited to specific purposes, such as for hospital beds or for each sterilization (VHS), or they may be block grants that are usually provided for a package of services. Similarly, funds from international donors tend to be project specific, rather than for core support.

The government hospitals receive the bulk of their funding from the state treasury. They levy user fees as well as tap local donations.

[1] At the time this study was conducted, the exchange rate for Indian rupees (Rs.) was approximately Rs. 35 per US$.

2.3 How Local Control Is Exercised

In all cases a local structure is used to facilitate local control. Some organizations used existing community structures such as *mahila mandal* (women's groups) or milk societies to exercise local control, while others set up special bodies such as village health committees, local action committees, or district health committees. The local bodies utilized by each of the examples are shown in Table 2-1.

The NGO, BSA, sets up committees at three levels:

- *Gram swarajya sabhas*, which are village councils consisting of representatives from each family, and a democratically elected president and secretary. Each project village has a village council.

- *Kshetriya gram swarajya sabhas*, which are area councils made up of the president and secretary of each village council. There is one area council for every 20 to 30 villages.

- *Kendriya gram swarajya sabha*, a central council made up of representatives from area councils and the BSA staff.

The Tribhovandas Foundation utilizes milk societies affiliated with the Amul dairy cooperative. RUHSA has set up village advisory committees, which have some decision-making authority and implementation responsibilities.

As for the public hospitals included in this review, government regulations do not permit public health institutions to levy charges and retain revenue raised at the facility level. As a way of by-passing this rule, some government institutions have set up and registered autonomous societies. The SMS Hospital in Jaipur has established the Rajasthan Medical Relief Society, and district-level hospitals in West Bengal have also registered autonomous societies. Both the Jaipur society and West Bengal committees are comprised of a mix of community representatives, including elected representatives and other prominent community members, and district government administrators. The government staff usually sit on committees in ex officio capacity.

Unfortunately, no information was available in the literature as to how these local structures function; that is, how often they meet, how members are selected (e.g., by nomination or election) and how exactly decisions are made. For the NGOs, the literature did not include information on the composition of local bodies.

2.4 The Scope of Community Control

Table 2-2 summarizes the scope of community control of health financing for the ten examples using the matrix of financing functions shown in Figure 1-1. As described below, the degree and scope of community financing control vary enormously across the NGOs and government hospitals.

Table 2-2
Scope of Community Control of Examples from the Literature

Financial Type of Responsibilities	1. AWARE	2. Sewa-gram	3. Child in Need Institute	4. Goalpara	5. RUHSA	6. Tribho-vandas Foundation	7. BSA	8. VHS	9. SMS Hospital, Jaipur	10. District Hospitals, West Bengal
	Type of Local Structure									
	Village Organiza-tions	Village Health Committees	Women's Groups	Village Health Committees	Society/ Village Advisory Committee	Milk Societies	People's Committees	Local Action Committees	Hospital Society Committee	District Hospital Committees
1. Ability to receive funds	Community contributions only	Community contributions only	Community contributions, government funds for income-generating activities	Prepayment contributions	Society to receive funds from all donors	Prepayment contributions	Community contribution and donor funds for local investment for income-generating activities	CHW collects prepayment donations	User fee revenue and donations	User fees and other local donations
2. Ability to spend funds	No authority	Community contributions only, against specified repetitive items	Can allocate loans for income generating activities	Yes, but no details given	Can define only spending priorities for community funds. Donor funding usually specified	No authority	Jointly with NGO	No powers	Can define own spending priorities for self-generated revenue (above sources)	Can define own spending priorities for self-generated revenue
3. Other financing responsibilities										
▲ Design of Project and Financing	No details given	Design of exemption scheme	No details	State responsible for fund management but no details given	No details	Yes, involved in design of community financing	Jointly with NGO	Involved in project design	Fee setting design of exemption	Fee setting/ exemption scheme
▲ Planning and Budgeting	No details	No details	No details	State responsible for fund management but no details given	No details	No details	No details	No	No details given	
▲ Administration of exemption schemes	No details	NA relevant	No details	State responsible for fund management but no details given	No details	Community health, Women responsible	No details	No	Yes	Yes
▲ Operate bank account	No details	No details	No details	State responsible for fund management but no details given	Yes	No	No details	No	Yes	Yes
▲ Financial reporting and monitoring	No details	No details	No details	State responsible for fund management but no details given		No	No details	No	Yes, produce annual report	Yes

2.4.1 Ability to Receive Funds

The majority of local institutions, including Goalpara, AWARE, VHS, Tribhovandas Foundation and Sewagram, are able to receive community-generated funds only. These funds include revenues from user fees, pre-payment contributions and other local donations. The RUHSA Society is able to accept funds from various income-generating activities, while the village councils under BSA can accept both community contributions as well as funds from the NGO for extension of credit for income-generation activities. The women's groups, mahila mandals, under Child in Need Institute, can receive community contributions as well as donor and government funds to support income-generating activities. The SMS Hospital and District Hospital Committees in West Bengal are able to tap donor funds as well as community funds.

2.4.2 Ability to Spend Funds

Three of the examples, VHS, AWARE and milk societies at the Tribhovandas Foundation, have no power whatsoever to spend funds. In all three cases, the local institutions or representatives, such as health workers, are responsible for collecting pre-payment contributions, but are required to hand over all revenue to the parent NGO. The local institutions or representatives under Goalpara and Sewagram have authority to spend only community-generated funds, which are pre-payment contributions in both cases. The health worker at Sewagram is able to spend funds against pre-determined expenditure items, namely drugs, transport and his/her own salary.

Several groups do, however, have considerably more spending authority. The village health committee at Goalpara, for example, appears to be able to determine its own spending priorities although not much detail is given. Local institutions under RUHSA, BSA, and Child in Need Institute have spending authority over both revenue from community contributions and funds from income-generating activities. At BSA, it appears that the village councils, together with an NGO representative, determine spending priorities jointly. The committees at the SMS Hospital in Jaipur and the district hospitals in West Bengal have complete authority to decide how to spend funds generated from user fees, as well as funds donated by the local community.

2.4.3 Other Financing Responsibilities

The majority of NGOs involved communities during project planning, including planning of financing activities. It is unclear from the literature, however, whether some of the communities were merely consulted or if they actively participated in financing decisions. The village health committee at Sewagram was actively involved in designing the pre-payment scheme. The committee members were asked to categorize households on the basis of their socioeconomic status. Premium levels were then set on a sliding basis, that is, lower income households were asked to pay less than higher income households. The committee used its own criteria to determine socioeconomic status. These criteria included cash income, whether the household owned land, whether agricultural laborers were employed and the number of dependents. In fact, the NGO felt that the income categories established by the community were more appropriate than the ones they would have used had they undertaken the task themselves. Moreover, the community decided that payment should be made in-kind in the form of grain rather than in cash because of the non-cash nature of the local economy.

The extent to which NGOs have handed over ongoing financial management responsibilities is harder to determine from the literature. It is mentioned that Goalpara is responsible for the

management of the pre-payment fund, but no further details are given. The SMS Hospital Society committee and the district hospital committees in West Bengal both operate bank accounts and have some financial reporting and monitoring responsibilities. In the SMS Hospital Society, the secretary is able to authorize expenditures of up to Rs. 500,000, usually for the purchase of equipment. The hospital has a separate purchase committee and a technical committee. The procedure for expenditures above this level is not mentioned.

AWARE aspires to create self-sustaining health societies. It helps to establish community organizations, and assists them in gaining access to development resources and government services. After six or seven years, AWARE gradually phases out, and once the community organizations have reached a certain level of autonomy, it withdraws completely. AWARE claims that it has already withdrawn from 380 villages, and has left behind 380 self-reliant community organizations. However, no information is given in the literature as to what responsibilities (especially financial) have been handed over, at what point they are handed over and how. Neither is it mentioned how the organizations are functioning in the areas where they have withdrawn.

There is considerably more experience among the NGOs in the local management of funds for income-generating activities than for health activities. For example, the mahila mandal under Child in Need Institute are responsible for disbursing loans for various income-generating activities, such as weaving. RUHSA has established a separate society for the production and marketing of various goods. A committee made up of representatives from different cooperative societies is responsible for managing the funds, including giving out loans for economic activities.

2.5 Why Local Control Was Initiated

In the NGO examples, local control of health financing was most often initiated within the context of a development philosophy, which advocates that communities themselves must take responsibility for their social and economic development needs. This was true in the case of AWARE, BSA, and RUHSA. The broader goal under this philosophy is community empowerment. This development approach perceives the NGO as a catalyst, which provides technical and other support, but which gradually hands over financial and other management responsibilities to communities. In some cases, such as AWARE, the long-term goal of the organization is to withdraw completely and hand over full responsibility to the community. However, this does not preclude technical support and guidance from outside individuals or institutions. It is believed that local control ensures that communities have a stake in health activities, and it also promotes self-reliance. In the long term, it also contributes to ensuring the sustainability of activities initiated by the NGO, both in financial and organizational terms.

Community financing was often introduced by NGOs as a pragmatic response to either an overall shortage of funds or unreliability of funding over the long term. Lack of flexibility that characterized some financing sources, such as grants from government and international donors, was another reason. In some cases, nominal charges were introduced in the belief that free services are undervalued, and services that are charged are perceived to be of higher quality.

In the case of the government hospitals, local control was introduced solely in response to chronic shortages of funds for non-salary recurrent expenses. Since almost 80 percent of government funds went toward meeting personnel costs, little was left for operational and maintenance costs, such as drugs, maintenance of equipment and buildings, and transport.

2.6 Community-Generated Financing

2.6.1 Methods of Community Financing

The NGOs and government hospitals use a number of community-generated financing sources, including user fees, pre-payment schemes, in-kind contributions and more general fund raising efforts. Each is described below. Equity concerns, if addressed by the organizations, are outlined and, where the literature permits, levels of cost recovery are estimated.

1. User Fees

User fees are defined as any payment made by clients directly to health providers at the time services are rendered. User fees are not widespread for community- based care. However, Child in Need Institute charges a nominal Rs. 1 registration fee in its maternal and child health (MCH) clinic, and Rs. 1 for a growth card. BSA also charges fees for basic drugs provided in its outreach program. Some organizations that run pre-payment schemes require that members make a co-payment before using services. For example, patients using the community services run by the Tribhovandas Foundation are charged for drugs at a subsidy, while members of the Goalpara pre-payment scheme are charged for drugs at cost. VHS, which also runs a community-based pre-payment scheme, charges non-members for a doctor consultation and for the full cost of drugs.

At the hospital level, fee collections represent a major source of income for VHS and are becoming an increasingly important source for the government hospitals as well. The VHS hospital levies different charges for members of the pre-payment scheme than for non-members. Patients are charged per item of service rendered, such as for a consultation, diagnostic tests, drugs, per inpatient day and operations. VHS also has private wards where patients are charged at a higher rate for all services than that in the regular wards. In the Jaipur government hospital, there is a Rs. 2 outpatient registration fee and a flat Rs. 5 fee for routine inpatient admissions. Patients referred by private practitioners are charged Rs. 10 for admission. In addition, charges are levied for diagnostic tests, daily inpatient stays and surgery at 50 percent of the market rate. The district hospitals in West Bengal also charge for services, but at present these are nominal and levied in an inconsistent manner. For example, charges are made for some diagnostic tests and not for others.

2. Pre-payment Schemes

These are usually contributions made by individuals or households in advance of the need for services. Since only the sick make use of services, risks are shared between the sick and the healthy. Pre-payment schemes may provide different levels of coverage for community-and hospital-based care, varying from partial to total coverage.

Four of the NGOs reviewed in the literature operate pre-payment schemes (VHS, Goalpara, Tribhovandas Foundation and Sewagram), all of which extend coverage to the household. Tribhovandas Foundation charges Rs. 10 per household per year, and Goalpara charges Rs. 18 either in cash or the equivalent in-kind. Both Sewagram and VHS have sliding premium levels. At Sewagram, sliding scale payments are made in the form of grain, while at VHS contributions vary from Rs. 12 per year for households that fall into the lowest-income group to a maximum of Rs. 300 for high-income households.

The schemes also differ in the types and levels of services that they cover. For example, at Sewagram members are entitled to free community care, including services of the community health worker, drugs and the services of the mobile clinic. At the hospital level, a differentiation is made between illness episodes that are planned and those that are unplanned, such as pregnancy and chronic ailments. Members are entitled to free care for unplanned illness episodes, and a 25 percent subsidy for planned illness episodes. The Tribhovandas Foundation scheme provides members free care from the community health worker, as well as drugs at subsidized rates and hospital care at 50 percent of cost. Goalpara provides free doctor consultations and drugs at cost.

Non-members are not entitled to the services at Sewagram, whereas at Goalpara, non-members can use the services, but are charged commercial rates for a doctor consultation and drugs. At Tribhovandas Foundation, non-members receive the same benefits as members at the primary-care level, but are not entitled to subsidized referral care. At VHS, non-members can use both community-based services and hospital care, but at a charge. The VHS scheme is not working effectively as a pre-payment scheme. Since there is no compulsory waiting period between joining the scheme and the ability to use services, patients tend to join only when they are in need of hospital care.

3. Other Community Financing Mechanisms

Other financing mechanisms include fund raising efforts, commercial schemes and in-kind contributions. Goalpara raises revenue by hosting charity plays and fairs, which represents five percent of their total income. At the VHS, the higher charges to private ward patients for inpatient stays, diagnostic tests, surgery, etc., is estimated to generate a surplus of 45 percent over costs.

At BSA, local people provided land and labor for the construction of the health center, and at AWARE, the community donated Rs.100,000 toward drug costs. At the SMS Hospital in Jaipur, a "life line fluid" store has been opened, which sells intravenous fluid and other surgical items at a profit.

2.6.2 Mechanisms to Ensure Equity

All 10 organizations implementing community financing had mechanisms in place to ensure that those who could not afford user fees, premiums or co-payments were not excluded from using services. User fees are waived partially or totally for patients considered unable to pay. Both Goalpara and Tribhovandas Foundation waive drug fees for those judged too poor to pay. At Tribhovandas, it's the responsibility of the community health worker to determine a patient's ability to pay, while at Goalpara, it is the doctor's. In both cases, capacity to pay is judged purely on a discretionary basis.

At the referral level, VHS charges for services on a sliding scale related to income. Individuals are categorized first into one of a number of income groups (those earning below Rs. 200 per month, those earning above Rs. 201 but below Rs. 300, those earning between Rs. 301 and Rs. 400, those earning between Rs. 401 and Rs. 500, and finally those earning more than Rs. 501). Again, determination is undertaken on an informal basis, although more formal evidence of income, such as an income certificate or ration card for those in casual employment, may be requested. At the SMS Hospital in Jaipur, those below the poverty line, as well as widows, orphans and senior citizens, are exempt from charges. At present, assessment is undertaken on a discretionary basis. In West Bengal, the poor are exempt from hospital charges when they produce an indigent certificate, which is issued by public officers. However, at present the system is greatly abused.

As mentioned already, some of the pre-payment schemes have equity considerations built into their design. At Sewagram and Goalpara, households have the option of paying in-kind or in cash. In addition, at Sewagram contributions are made on a sliding scale based on income categories determined by the community.

2.6.3 Level of Cost Recovery

The level of costs covered by community financing significantly varies across the 10 examples. Pre-payment contributions at Sewagram cover approximately 96 percent of all community-based costs. This includes the salary of the village health worker, drugs and mobile support costs. Referral costs are covered by other sources. At Tribhovandas Foundation, membership fee income and drug collections together cover approximately 70 percent of community health costs, including the salary of the community health worker and drug costs. The milk societies and donors cover the balance. At AWARE, community contributions cover 24 percent of the costs of health and other services combined. At the SMS Hospital, user fees generated Rs. 18.2 million, which represents 16.5 percent of total annual expenditures (Rs. 110 million).

2.7 How Local Control Is Working and Its Impact

It is difficult to conclude how local control is working and its impact. The literature contains very little information on how the local structures are functioning. All of the NGOs report a high level of service utilization, and some, like Child in Need Institute, also note improvements in health status in their catchment areas as indicated by reductions in infant mortality and improvements in nutritional status of children. However, the extent to which this can be attributed to local control of health financing is hard to say. The impact of local control can, however, be assessed in terms of improvements in quality, equity and financial soundness of health programs.

It is clear that community responsibility for the design of the pre-payment scheme in Sewagram resulted in greater equity in the provision of health services. The village health committee decided that households be categorized on the basis of income, and pre-payment contributions be charged on a sliding scale. The committee devised its own criteria for assessing income, which the NGO acknowledged to be more valid than the criteria they would have used themselves.

It is also evident that financial contributions from the community can increase the self-reliance and sustainability of health activities. As mentioned above, pre-payment contributions covered 96 percent of Sewagram's costs of outreach health services, and 70 percent of the costs of the Tribhovandas Foundation's community health program. In the case of the Jaipur government hospital (SMS), the funds generated from user fees and other local sources were used by the hospital society to supplement the grossly inadequate funds from the government. The locally raised funds were used directly to make quality improvements, including the purchase of new equipment, maintenance of existing equipment and the maintenance and cleaning of the hospital buildings. In some cases, community financing represents a more stable, as well as more flexible, source of revenue compared to government or donor funds, which are often limited to specific expenditure items, rarely cover care costs, and are often for a fixed period of time.

The NGO, AWARE, appears to provide a model of self-sufficiency in which responsibility for health and other development activities is gradually handed over to village committees, which assume complete control once they are considered to have sufficient capacity. As previously mentioned, the

organization claims to have created 380 self-reliant village committees, though little information exists in the literature on how these committees are functioning and how self-sufficient they are.

3. Mini Case Studies of Community-Controlled Health Financing

Five mini case studies were undertaken to obtain more in-depth information on experiences with local control of health financing. As mentioned in Section 1.3, cases were selected where local communities were known to have at least some control over the mobilization and management of health funds or funds for other development activities. There also needed to be a visible local structure or group through which control was being exercised.

The five selected examples are:

- Mallur Health Cooperative in Karnataka state
- Aga Khan Health Services (AKHS) in Sidhpur, Gujarat state
- Urmul *Marusthali Bunker Vikas Samiti*, Phalodi (UMBVSP), in Rajasthan state
- Rangabelia *Mahila Samiti* (RMS) in West Bengal
- *Panchayati Raj* Institutions (PRIs) in the state of Kerala

Brief descriptions of the five cases are given in Figure 3-1. Main characteristics of the cases are summarized in Tables 3-1 and 3-2. Full case study descriptions can be found in Annex B.

Below we describe the organizations that promote local control, the services they provide, their major sources of funding, and how local control was initiated. The composition and functioning of the local institutions through which financing control is exercised are described, followed by an assessment of the scope of financing control, using the matrix shown in Figure 1-1, and specifics on the community financing strategies used. Finally, an attempt is made to examine what impact local control has had on the quality, equity and financial soundness of health care services in each study area.

3.1 Type of Organizations, Communities Served, Services Provided, and Sources of Financing

3.1.1 Communities Served

All organizations serve rural populations. Community control is most often at the village level or at most covers two or three villages. However, the total population served by the organizations varies between 5,000 (for village-level *panchayats*) to almost 300,000 (in the case of UMBVSP).

Figure 3-1
Summary Descriptions of Case Study Examples

1. Mallur Health Cooperative

This cooperative, situated in a rural village in Karnataka, provides health care to a population of 7,000. Health services provided include a three-bed health center staffed by a doctor, an auxiliary nurse, and a pharmacist. Outreach care is provided in the form of specialist camps.

The Cooperative Health Committee is a registered body established by the local dairy cooperative. Initially, health services were financed by an earmarked tax on milk sales. However, as economic and social activities of the cooperative diversified, separate management committees were established, and the health cooperative delinked from the dairy cooperative. A parent body, the Gram Bhivruddhi Sangha, was set up to oversee all social service activities, including health.

Health services are currently financed from two main sources: user charges and interest earned on an amendment deposit.

The Cooperative Health Committee comprises nine members who serve on a voluntary basis. They are nominated by members of the parent body and cooperative committee members. Tenure is for three years. The health center doctor and a faculty member from the St. Johns Medical College are committee members. The committee has sole financial responsibility.

2. Aga Khan Health Services, Sidhpur (AKHS)

AKHS is a private, non-profit organization supporting a community-based health project in Sidhpur, Gujarat. AKHS serves in areas that have a sizable population of Ismailis (followers of a religious sect of Islam). Health services are provided at three levels: community, a health center, and a diagnostic center, providing radiography and ultrasound facilities. Approximately 23 villages are covered by the project, or a population of 40,000.

Health services are funded from a number sources, including funds raised by AKHS from other donors (such as USAID, and community financing (including user charges and a prepayment scheme).

AKHS has set up a three-tier system of committees to manage and Implement health services. The first tier has sector health committees that represent the local structures through which financing control is exercised. Sector committees have no legal status (that is, they are not registered bodies).

3. Urmul *Marusthali Bunker Vikas Samiti*, Phalodi (UMBVSP)

The UMBVSP is an autonomous registered society providing health and other development activities in the Thar desert of Rajasthan. They society started as a cooperative of weavers and gradually undertook other social and economic activities, such as health, agriculture, and education. The society receives some support from the Urmul Trust, including technical assistance and help In securing donor funding.

Health activities include helping to access health care from the government sector, tuberculosis care, malaria control, and health education. The main sources of funding are donor funds and profits from income-generating activities. Effectively, the community also pays for health care since the society reimburses the costs of care on the basis of income.

The society itself represents the institution through which local control of health financing is exercised. Further community involvement is sought through a network of community organizations, including women's groups and village committees.

4. Rangabelia *Mahila Samiti* (RMS)

RMS is an operational wing of the Tagore Society for Rural Development (TSRD), a voluntary non-profit organization that provides micro-enterprise activities, training and other development services for poor rural women in the Sundarban area of West Bengal. With the support of TSRD, RMS provides health care services in 60 villages via a health center, a mobile clinic, and outreach clinics. RMS is totally dependent on donor funding.

The RMS council represents the local institution through which financing control is exercised. However, since it is not a registered body, it cannot receive funds directly. The council uses a network of community groups and committees to elicit community involvement in planning and implementation. Links are also maintained with its sister organization, the woman's cooperative society, a registered organization through which income-generating activities are implemented.

5. *Panchayati Raj* Institutions (PRI)

The Panchayati Raj Act was introduced through a constitutional amendment in 1991. PRIs are "institutions of self-government" that complement the official government structure. The legislation sets up a three-tier system of *panchayats* at village, block, and district levels. The *panchayati* seats are filled by direct election every five years and some seats are reserved for Scheduled Castes and Scheduled Tribes, and for women.

Kerala is one of the three states that has shown a great commitment to *panchayati raj*. Over the last year, significant responsibilities for management and implementation of public health services have been handed over to block and *gram* (village) *panchayats*. This includes significant financing responsibilities. PRIs have also been involved in planning under the ninth five-year development plan, including for health. Forty percent of plan resources will be spent through PRIs.

Table 3-1
Basic Information on Mini Case Study Examples

Name	Location	Population Served	Health and Other Services Provided	Total Annual Budget (rupees)	Sources of Funding
Mallur Health Cooperative	Rural Karnataka	7,000	Health center (inpatient and outpatient care), specialized camps. Other: education, economic activities	225,000	Interest earnings from endowment fund, user fees
Aga Khan Health Services, Sidhpur (AKHS)	Rural Gujarat	40,000	Outreach health workers, health centers, diagnostic center. Other: sanitation	Approximately 90,000 per sector	Donor, local donations, user fees, pre-payment
Urmul *Marusthali Bunker Vikas Samiti* Phalodi (UMBVSP)	Rural Rajasthan	290,917 (90 villages)	Tuberculosis control, immunizations, malaria, health education	8,644,463	Donor, income-generating activities, user fees
Rangabelia *Mahila Samiti* (RMS)	Rural West Bengal	Approximately 300,000 (100 villages)	Health center, mobile clinic, outreach clinic posts	(not available)	Donors, government
Panchayati Raj Institutions (PRI) (village and block levels)	Rural Kerala	Village level: 5,000 Block level: 100,000	Village level: sanitation, supervision of health worker, all public health activities. Block level: PHC center	Approximately 10-12 million at both the village and block levels	Government grants, taxes

Table 3-2
Institutional Relationships: Organizational Status, Affiliations, and Local Structures with Financing Powers

Organization	Status	Affiliated Organizations	Relationship	Local Structures with Financing Powers
Mallur Health Cooperative	Registered society	Gram Bhivruddhi Sangha	Parent body responsible for coordinating all economic and development activities (including health)	Cooperative Health Committee
Aga Khan Health Services, Sidhpur	Registered non-profit NGO	None	Not applicable	Health committees at sector, zone, and project levels
Urmul *Marusthali Bunker Vikas Samiti*, Phalodi (UMBVSP)	Registered society	Urmul Trust	Helped establish Society, provides some ongoing technical support and helps identify funding sources	UMBVSP Society plus network of village organizations (such as women's groups and village committees)
Rangabelia *Mahila Samiti* (RMS)	No legal status	Tagore Society for Rural Development and Rangabelia Mahila Industrial Cooperative Society	Tagore Society for Rural Development sets up RMS and provides ongoing support in project management, including channeling of funds. RMS Industrial Cooperative Society is a sister organization through which income-generating activities are managed and implemented	RMS Council plus network of village groups and zonal committees
Village and Block *Panchayats*	Local elected bodies	None	Not applicable	*Panchayati Raj* Institutions themselves

The socioeconomic status of community served, as indicated by proxy measures of education, employment and ownership of assets, varies for the five organizations. For example, the area served by the Mallur Health Cooperative is relatively wealthy, with approximately 50 percent of households owning land. Roughly 20 percent of households own a scooter, and between 70 to 80 percent own a television. Dairy farming and sericulture are the main economic activities. In contrast, the communities represented by UMBVSP and RMS are relatively impoverished and are located in particularly harsh environments. UMBVSP is based in the Thar desert in the state of Rajasthan, a drought-prone area with one of the lowest literacy rates in the country (30 percent). The main target populations of UMBVSP are those from the Scheduled Castes and Tribes[2] and lower-class Muslims. RMS is located in a group of islands in the estuarine rivers of South Bengal, an area prone to floods and cyclones.

The community served by AKHS is more mixed in socioeconomic terms. The organization always serves in areas with a significant Ismaili population (a religious sect of Islam). In Sidhpur (the project area studied), Ismailis make up 19 percent of the population. This religious minority tends to be relatively wealthier than other segments of the community, as well as better educated. The majority of non-Ismailis are engaged in agricultural activities.

3.1.2 Institutional Relationships

The five organizations differ considerably in their status, their affiliation to other organizations, and their relationship to the local institutions having financing control. These in turn influence their ability to receive funds and the scope of local control (which is examined in Section 3.4). These factors are summarized in Table 3-2.

Three of the organizations (UMBVSP, Mallur, and AKHS) are registered non-profit societies. RMS has no legal status, while the PRIs are locally elected bodies. Three of the organizations (UMBVSP, Mallur, and RMS) are affiliated to other institutions. In all three cases, the affiliated institution (Urmul Trust, Gram Bhivrudhi Sanhga, Tagore Society for Rural Development, respectively) helped to set up the organization. However, their ongoing relationships differ. At Mallur, the parent body has a coordinating role only; whereas, at UMBVSP, the affiliated organization plays a supportive role, providing technical assistance and helping to identify potential donors. At RMS, however, the Tagore Society continues to play an active role in project management and financing.

In all cases but AKHS, an international NGO with project sites throughout India, the organization itself is the local institution through which financing control is exercised. At UMBVSP and RMS, community participation is also carried out through a network of grassroots organizations, such as women's groups and village committees. At AKHS, local control is exercised through health committees at three levels: sector, zone and project.

[2] Scheduled Caste and Scheduled Tribe are official terms used by the government of India to denote those from the lower caste groups. They represent relatively poorer sections of the population and have less access to basic education, health service, and employment opportunities.

3.1.3 Health and Other Services Provided

In the cases of Mallur, AKHS, and RMS, local communities are responsible for operating health centers that provide both outpatient and inpatient care services. These three organizations also provide outreach services through community health workers in the case of AKHS, via a mobile health clinic in the case of RMS, and through periodic specialized medical camps in the case of Mallur. In addition, AKHS runs a diagnostic center, which has ultrasound, radiology, and laboratory facilities.

UMBVSP runs tuberculosis and malaria control programs, as well as ongoing health education and immunization activities. Much of UMBVSP's health efforts are aimed at supplementing government services, and helping community members to access these services.

The Kerala state Panchayati Raj Act states that village-level (gram) panchayats are responsible for public health and sanitation services. These responsibilities include: management and control of government dispensaries, supervision of outreach workers, health education and epidemic control, including immunization, and blood and eye donation. Block panchayats are responsible for managing the block primary health center, the control and prevention of infectious diseases, organizing health awareness camps and raising awareness of health issues related to woman and children.

These groups also provide a variety of other (non-health) services. These include income-generating activities (UMBVSP, RMS, Mallur), environmental sanitation (AKHS), and education (Mallur).

3.1.4 Sources and Levels of Health Financing

The five organizations obtain funding from multiple sources. These include: user fees (AKHS, Mallur), interest earned on an endowment fund (Mallur), local and external donor funds (UMBVSP, RMS, AKHS), central and state government grants (PRIs), tax revenue (PRIs), and a pre-payment scheme (AKHS). It was not possible in all cases to determine the volume of funds controlled locally. However, we do know that the communities in the Mallur Health Cooperative area manage an annual budget of Rs. 225,000, and that the village and block panchayats each have an annual budget of about Rs. 10 million to Rs. 12 million from all sources combined. Sources of community financing are described more fully in Section 3.5.

3.2 How Community-Controlled Health Financing Was Initiated

In the cases of AKHS and RMS, efforts in local control were initiated by an external NGO—Aga Khan Health Services and the Tagore Society, respectively. In both cases, the NGO continues to play a central role in the provision and management of health and other social services. Local control was initiated by the NGOs in the belief that the communities themselves must participate and take responsibility for their health and other development needs. AKHS established a multi-tier system of health committees to facilitate local control, and RMS set up a network of village groups and zonal level committees. AKHS views local responsibility and control as a continuum, with four main phases:

Phase 1: Community involvement in project planning.

Phase 2: Once implementation begins, health communities take responsibility for day-to-day management of health services.

Phase 3: Health committees take on some management and financial responsibilities; decisions are made jointly by communities and the NGO.

Phase 4: Health committees are given full management and financial control. At this stage, committees are registered, autonomous bodies.

Authority and responsibilities are handed over in this phased manner as local structures are strengthened. Local control and responsibility are given added emphasis due to AKHS's religious orientation since the Ismaili faith stresses civic duty and voluntary action. AKHS also places great emphasis on community financing and the financial sustainability of services. A discussion on where AKHS committees currently are along the continuum is found in Section 3.4.

In the cases of UMBVSP and the Mallur Health Cooperative, local communities organized for economic reasons. Health and other social services were then added on to these economic initiatives. For UMBVSP, the severe drought of 1984–1987 a prompted weavers in the Jaisalmer district of Rajasthan to form a cooperative for the collective production and marketing of textiles. An NGO—the Urmul Trust—helped set up the UMBVSP Society and continues to provide technical and other support, including help in securing donor funding.

At Mallur, it was dairy farming that brought communities together. The village, with strong support from two influential community leaders (the president of the dairy cooperative and a local member of the legislative council), established a cooperative to facilitate the collective purchase of fodder and the sale of milk. The cooperative approached the Community Medicine Department of St. Johns Medical College for technical support. This support continues today, and a faculty member of the college sits on the cooperative health committee.

In the initial stages, health services at Mallur were financed directly from milk sales. However, as the village expanded both its economic base and its social service activities, a separate society was established for the social service activities (the Gram Bhivrudhi Sangha), and health financing was de-linked from the dairy cooperative. Separate committees were then set up to manage the different economic and social activities (including a cooperative health committee), all under the umbrella of the society.

In the case of RMS, two organizations were set up by the Tagore Society for Rural Development: (1) an operational wing of the society, RMS, which manages health and other social service activities, and (2) the RMS Industrial Cooperative Society, a registered, independent organization established to implement income-generating activities. Health activities are thus managed separately from income-generating activities, although some individuals sit on both the Industrial Cooperative Society board and the RMS Council. Funds for health activities are channeled to RMS through the Tagore Society and local control is exercised through village organizations, namely, women's groups and village committees.

PRIs are institutions of self-government that complement the official government structure. They came to be formally recognized in 1993 through a constitutional amendment. In essence, they were created in response to the over-centralization of administrative authority and the perceived lack of accountability of government bureaucrats. The panchayati raj legislation established a three-tier system of panchayats: (1) village panchayat for a village or group of villages that are composed of up

to 5,000 people, (2) block panchayat covering approximately 100,000 people, and (3) district panchayat covering between 500,000 and 1,500,000 people.

3.3 Composition and Functioning of Local Institutions

In each case, local control is exercised through a variety of community institutions and structures (see Table 3-2). As already mentioned, their legal status varies, as does the means by which members are selected. This section briefly describes the composition of the local structures in the five case study examples and how they function, including how decisions concerning funds are reached, the length of the tenure of members, and how often they meet. An assessment is also made as to how representative of the community these groups are in terms of income, gender and caste. Their capacity to carry out their management and technical responsibilities is also assessed.

3.3.1 Local Institutions

AKHS promotes local control through a multi-tier system of committees. At the first level is the Health Sector Management Committee (HSMC), at the next level the Zonal Management Committee (ZMC), and the highest level the Project Management Committee. In the early stages of the project, there were also Village Health Committees, which played an important role during project planning. However, they were recently dissolved since it was felt that they constituted an unnecessary layer of management. The various committees at present have no legal status, although AKHS plans to register them as autonomous bodies once they are sufficiently strong.

At RMS, local control is exercised through a council and a network of village groups and zonal committees. Though not registered, RMS is able to wield some influence through its sister organization, the Rangabelia Mahila Industrial Cooperative Society, a registered body representing a number of different women's cooperatives, as well as through its parent organization, the Tagore Society.

At Mallur, local control is exercised through the Cooperative Health Committee. The committee is under the Gram Bhivruddhi Sangha, the registered non-profit–making society created by the cooperative to manage social service activities. At UMBVSP, the UMBVSP Society, together with a network of grassroots organizations, including women's groups and village committees, exert control on behalf of local communities. The UMBVSP Society is a registered body.

PRIs are themselves the vehicle by which local control is exerted. They are autonomous institutions of self-government.

3.3.2 Size, Composition, and Terms of Membership of the Local Distributions

At AKHS, Sidhpur, each of the committees has a "convener" (equivalent to a chairperson), and a secretary. The HSMC has five other members, while the zonal-level committee has eight other members. The Mallur Cooperative Health Committee, which is covered under the Non-Profit Making Society Act, has nine members, including a secretary and a treasurer. The act also makes it compulsory to have at least one woman member. The UMBVSP Society is governed by a 12-member managing board, including a chief executive secretary. Each of the women's groups and village committees has an eight-member executive committee, including a secretary and treasurer. As for the block and village panchayats, each has 11 members.

With the exception of the PRIs, members of all local structures serve on a voluntary basis, and are nominated either by the parent body or society (Gram Bhivruddhi Sangha at Mallur or the Cooperative Society at UMBVSP) or by the other committee members. The criteria for selection of members in these organizations include: previous experience in community service, education, time available and acceptability by the community. Tenure for members is fixed for all local structures and varies between one year for members of the sector-level committees under AKHS and the local organizations under UMBVSP and to three years for Mallur Cooperative Health Committee members.

Panchayati raj representatives are elected by the public. They usually represent a political party, but they may also stand as independent candidates. The *Panchayati Raj* Act states that elections should be held every five years. In Kerala, however, the last elections were held after a period of seven years.

The degree to which local structures are representative of the community they aim to serve, in terms of gender, caste, and class, varies. In the case of the AKHS, the committees are not representative, since Ismailis dominate each of the different committees. The Ismailis make up approximately 70 percent of members, although they comprise only 19 percent of the population. Female representation was low at the beginning. This has been redressed slightly with the recruitment of community health workers onto sector committees. This may not have been an adequate response since the health workers are not very vocal, and appear to have a low awareness of project management and financing issues.

In the case of the PRIs, the act that created them mandates that 30 percent of all members must be women and that at least one of the 11 members must be from a Scheduled Caste or Scheduled Tribe. These requirements have helped ensure that these groups are adequately represented on the PRIs. At one village panchayat visited, the president was a woman, as were three of the other 11 members. Elected representatives were from a cross section of society, and included: a farmer, a mine worker, a toddy tapper (local alcohol producer) and a business man. In terms of political representation, the panchayat was dominated by a single party, the communist party of India (Marxist)(CPM); seven of the 11 members represented the CPM; one represented the CPI (Communist Party of India); one represented the Indian National Congress; one represented the Congress I; and one representative was an independent.

As for the three other organizations studied, the caste composition of the Mallur Cooperative Health Committee appears to exactly mirror that of the community it serves. This is also the case at UMBVSP, where members of the local structure appear to be largely drawn from the weaving community, and from scheduled caste and lower-class Muslims—the section of the community that they target for health and other development activities. And at RMS, the local village committees are comprised of community leaders, village representatives, as well as panchayat representatives.

3.3.3 How Does the Local Group Function?

Most local groups meet monthly, except the PRIs, which meet twice a month. Decisions in all cases are made by consensus, usually reached by debate and discussion. At PRIs, if they are not able to reach a mutual decision, they may ask for a vote. However, this appears to be rare.

The degree to which all voices are heard also varies significantly across the organizations. During the early years, Mallur was dominated by two persons (the founders). The Cooperative

Health Committee was fairly autocratic at this time, although it has since been described as a "benevolent dictatorship." However, a second line of leadership was later developed, which has helped ensure the sustainability of the committee. The author was informed that the present committee is more democratic than before, and that members in fact have an equal voice in committee matters. There also appears to be a more regular turnover of committee members. In contrast, AKHS committees appear to be dominated by the chairperson and secretary. The community health workers were generally quiet and had limited knowledge of some basic program details.

Some of the local structures have regulations that ensure their accountability to the community they serve. For example, the Mallur Cooperative Health Committee holds a general meeting every year, to which the entire village is invited. This provides an opportunity for the public to ask questions and to make any demands. The PRIs are required to notify the public about unit costs when undertaking construction or maintenance work, which makes them directly accountable to the community.

The technical and management capacity of the local groups to carry out their responsibilities varies considerably. None had received any formal training, in either technical or management areas. Some training on an ad-hoc basis had been given to the AKHS committees and to the PRIs. Mallur was the only local structure to have members who are qualified health professionals. Both the health center doctor and a faculty member from the St. Johns Medical College are members of the Cooperative Committee, which enhances the committee's technical capacity. Other local structures—like those of UMBVSP, RMS, and AKHS—do not have in-house professionals, but are able to seek technical advice from their supporting NGOs or societies.

Most of the local structures in the five cases maintain links with other local institutions, either on a formal or informal basis. Mallur maintains contact with the local panchayat as well as the government primary health center. At RMS, contact with other community groups and the panchayat is more easily maintained since panchayat members as well as other community representatives sit on their local committees.

3.4 Scope and Degree of Community Control of Health Financing

The scope of community-controlled health financing is analyzed using the matrix of health financing functions shown in Figure 1-1. Table 3-3 summarizes the scope and degree of community control for each of these functions for the five case study examples.

3.4.1 Ability to Receive Funds

The status of the local institutions influences whether they are able to receive funds directly or whether funds have to be channeled through an intermediary organization. For example, the sector committees under AKHS and the RMS Council are not registered bodies, and as a result are not able to receive funds directly. The AKHS and the parent body of RMS (Tagore Society) act as conduits for channeling funds to the committees and the council, respectively. Although the AKHS sector committees collect community contributions—in the form of user charges and pre-payment, contributions—they are not able to retain these revenues and must pass them on to the AKHSs Project Management Committee.

In contrast, the UMBVSP Society and Mallur Cooperative Health Committee are registered as non-profit making bodies. This empowers them to receive funds directly from any source. The PRIs, as political institutions, are able to receive government grants (both state and national), as well as revenue from local taxes. However, they are not permitted to receive funds directly from donors.

Table 3-3
Scope of Community-Controlled Health Financing for Case Study Examples

Financing Function	Organization and Local Institution				
	Mallur Cooperative Health Committee	**AKHS (Sector Health Committees)**	**RMS Council**	**UMBVSP Society**	**PRIs (Village and Block)**
1. Ability to receive funds	Able to receive from any source, current sources: user fees, interest on deposit	Responsible for collecting community contributions (user fees plus pre-payment)	Funds are to be channeled through the Tagore Society for Rural Development, an NGO	Can receive funds directly from any source (current donor fees only)	Can receive government grants and revenue from local taxes
2. Ability to spend funds	Can define over-spending entities for all funding sources	Allocate against pre-determined expenditure items	Only against pre-agreed expenditure items	Usually agreed upon with donor	Government funds usually earmarked for specific expenditures, can use tax revenue at own discretion
3. Other financing responsibilities					
▲ Design of project/financing scheme	Committee designed both project and financing strategy with external council support	Method of financing Setting fee levels	Jointly with NGO	Society designed medical reimbursement scheme	
▲ Planning and budgeting	Annual plan and budget prepared	Involved in annual planning and budgeting	Prepare annual plan and budget	Prepare annual plan and budget	Involved in planning for ninth five-year plan. Prepare budget statements
▲ Administration of exemption scheme	No (health center staff decides who to exempt)	Yes, decide who to exempt	Not relevant	Identify who should be reimbursed at what level	Not relevant
▲ Financial reporting and monitoring	Has registered society have to publish annual report and financial statements	Have to complete monthly financial statements	Yes, to Tagore Society for Rural Development	Required to prepare annual report and financial statement	Responsible for financial reporting and monitoring

3.4.2 Ability to Spend Funds

The ability to freely spend funds differs considerably among the five examples studied. UMBVSP Society and Mallur Cooperative Health Committee are able to use funds raised from all sources, including interest generated from Mallur's endowment fund and revenue from user fees. Both groups have sole responsibility for prioritizing health expenditures and deciding how to allocate funds. At Mallur, the committee utilizes user fee revenue to meet all non-salary operational costs, and interest earnings to pay salaries. The UMBVSP Society is responsible for meeting all costs related to

the reimbursement scheme for delivery and accidental emergency cases, as well as for the treatment of tuberculosis.

PRIs have control of government grants and revenue raised from local taxes. They are able to decide how best to spend locally generated revenue. However, government grants, at least those on the non-plan revenue side, are usually earmarked for specific expenditures, and thus they have less discretion regarding the use of these funds. However, since government funding is usually inadequate to meet all requirements, tax revenue is often used to meet expenditure deficits. This is most often for capital expenditures, such as building maintenance or construction.

The RMS council decides jointly with the Tagore Society how to allocate resources. They undertake a joint planning and budgeting exercise every year (see below). The Tagore Society then disburses funds to RMS against this budget. On the other hand, health committees under Aga Khan Health Services appear to have a limited say on how funds are spent. AKHS has established a standard package of health services in each sector, which are delivered in an identical manner. AKHS disburses funds to the committee to meet certain expenditures only. For example, they are responsible for paying the electricity bill for the health center, but are not able to buy drugs.

3.4.3 Other Financing Responsibilities

Local communities under Mallur and UMBVSP have sole responsibility for implementing and managing health activities. At Mallur, the Cooperative Health Committee is responsible for the day-to-day running of the health center, including approving the monthly drug budget, approving repairs to the building and equipment, and purchasing new equipment. At UMBVSP, the Society, together with the village committees, manage health activities. At AKHS, sector committees currently appear to be between phases two and three along the continuum of local responsibility described in Section 3.2. Committees have responsibility for the day-to-day management of health services, and have limited management and financial responsibilities. They are responsible for setting fee levels, deciding who should be exempt from charges, paying certain bills and salaries (including electricity and telephone bills and sweepers' salary), buying stationery, administering lady health visitors' travel allowances for local health volunteers, and purchasing emergency medicines. Management decisions, however, still appear to be made largely by the Project Management Committee.

Although the constitutional amendment of 1992 stipulates that authority be given to the PRIs, in practice the transfer of power has been gradual. The PRIs in Kerala currently have partial control of public health facilities up to the district level. Management responsibilities are shared with the district health administration. Since last year, PRIs in Kerala have all health management-related responsibilities, except paying health staff salaries and purchasing drugs. At the moment, PHC doctors have dual reporting lines: they report to the district medical officer for technical matters, and to the panchayat representative for administrative matters, such as permission to take leave. And although they have some power to discipline health staff, PRIs are not able to hire, fire, or transfer staff.

Examples of specific financing responsibilities are described below:

(a) Design of Health Program and Financing Strategies

To some extent, all the groups were involved in designing health activities, including financing strategies. At AKHS, community involvement was sought during project design. Village-level committees were set up, and consultations held with communities regarding their health needs. The communities were also involved in deciding the type of community financing to be implemented. For example, it was decided jointly by AKHS and the community that user fees would be the main method of community financing. The communities also determined the fee levels.

The Mallur Health Cooperative Committee can decide which financing method to use. For example, they recently decided that salaries of health staff should be supplemented with incentive payments. The doctor now receives a portion of income from each laboratory test undertaken or home visit made.

(b) Planning and Budgeting

At AKHS, zonal-level committees have responsibility for ongoing strategic planning. As already mentioned, the RMS council and local village groups, together with the Tagore Society, draw up an annual plan and budget. Similarly, the UMBVSP Society, together with other local groups (such as women's groups and village committees), are responsible for undertaking planning on an annual basis.

The state of Kerala recently made the decision to allocate 40 percent of all resources for all social and economic sectors under the ninth Five-Year Plan to PRIs. PRIs have consequently been involved in undertaking local needs assessments and drawing up development plans, including those for the health sector. Planning was undertaken through *gram sabhas* or village councils, which represent all people eligible to vote in a ward (the smallest electoral unit).

(c) Administration of Exemption Schemes

In the case of AKHS, the sector health committees are responsible for undertaking means testing. They decide who should be exempted from user charges. Since committee members know most of the households in their catchment area and their economic situation, they find the task of means testing fairly easy.

UMBVSP provides reimbursement for delivery and emergency cases on a sliding scale based on income and ownership of assets. Patients are charged 100 percent, 50 percent, or 25 percent of the total cost. The Society is responsible for categorizing individuals into income groups.

(d) Operation of Bank Account

The Mallur committee, UMBVSP and PRIs all operate their own bank accounts.

(e) Financial Reporting and Monitoring

All local institutions have financial reporting and monitoring requirements. In the case of AKHS, the chairperson of the sector committee receives a monthly advance of up to Rs. 500 to meet operational expenditures, excluding staff salaries and drugs. They must report these expenditures against this advance every month. Each sector is a designated cost center; that is, all costs and income have to be estimated individually for each sector. Costs shared jointly by sectors, such as the doctor's salary and support from the AKHS project office, are apportioned to all sectors equally. The sector committees have to prepare and submit monthly financial reports that list all revenue raised and expenses made during the month. In this way, the exact financial performance of any one sector can be monitored. This method also facilitates cross-subsidization between the sectors.

3.5 Specifics on Community Financing Strategies

3.5.1 Community Financing Mechanisms

Four out of the five case study examples (AKHS, Mallur, UMBVSP, and PRIs) tap community contributions. Sources of community financing include user fees, pre-payment schemes, local donations, commercial activities, a medical reimbursement scheme and taxes. AKHS and Mallur tap contributions in the form of user fees, which they charge per item of service rendered (e.g., for registration, a doctor consultation, diagnostic tests or drugs). The Mallur Project charges for drugs at cost plus a 10 percent mark up. This system replaced the use of taxes on the sale of milk that financed health activities early on in the project.

At AKHS, several sectors operate different pre-payment schemes. Under one scheme, households can contribute toward different packages of health services. One package is for maternal and child health care (MCH), and includes ante-natal, delivery, and postnatal care. Another package provides screening services for non-communicable diseases, such as diabetes and hypertension. Another sector has agreed to a scheme to cover members of a dairy cooperative. The cooperative pays the health center a portion of the annual profits generated from milk sales. In return, members get free consultations, screening and a discount on services. AKHS also runs a diagnostic center as a commercial activity. They charge cost plus a 10 percent mark up.

UMBVSP operates a medical reimbursement system for labor and delivery, emergency, and tuberculosis services. In effect, this scheme functions in the same way as levying user fees, since patients are reimbursed for a portion of the costs that they pay for these services.

PRIs raise community contributions in the form of taxes. PRIs are entitled to levy the following taxes: property, professional (or registration), entertainment, establishment and sales taxes. Tax revenue is retained by the PRI and used for all activities. It is not earmarked for specific sectors (e.g., health).

3.5.2 How the Community Financing Strategy Was Designed

AKHS was the only organization to undertake a rigorous community assessment prior to introducing community financing. This assessment involved: a socioeconomic survey, estimation of household out-of-pocket expenditure, community perceptions and preferences regarding health care

financing, and current utilization of services. Communities were presented the findings of these surveys, and were involved jointly in making financing decisions based on these findings.

3.5.3 Equity Considerations

Three organizations have mechanisms in place to protect the poor from the burden of community financing. Mallur charges a consultation fee of only Rs. 1 to those from Scheduled Castes and Scheduled Tribes and waives all subsequent fees for those who cannot pay, which on average amounts to five to six patients per week. AKHS also waives fees for the poor. The sector committees who determine who should be exempt do not find means testing difficult, since most patients are known to them.

UMBVSP reimburses patients on a sliding scale basis, depending on their income and assets owned. The reimbursement rates are 75 percent, 50 percent, or 0 percent of the cost of care.

In contrast, community financing implemented by PRIs may be regressive rather than progressive. This is because the taxes they levy, such as sales taxes, are not related to income. As a result, the financing burden falls disproportionately on people with low income.

3.5.4 Levels of Cost Recovery

Given the time constraints of this study, we were able to obtain only limited information on cost recovery performance among the five cases. User fees generated by Mallur are reportedly sufficient to cover all non-salary operational costs. AKHS places great emphasis on cost recovery, and expects sectors to cover 15 percent of their operational costs from community financing in the first year and 60 percent by the third year. Most sectors have surpassed their targets, and are already covering between 50 to 70 percent of total costs. The diagnostic center is recovering 110 percent of its costs, and is using the surplus to cross-subsidize other sector-level costs.

3.6 Impact of Community Control

Due to a lack of empirical information, it was difficult to assess the actual impact of community control of health financing on utilization, quality, equity, and sustainability of the health services. In addition, in the case of the PRIs in Kerala, the community has had financial control for less than one year, and thus it is too early to draw conclusions about impact. The following discussion is therefore based largely on anecdotal evidence gained during discussions with members of local groups.

3.6.1 Utilization and Quality of Care

In several of the cases, funds generated from community financing have been retained and used by local communities to improve the quality of health services. This includes maintenance of buildings (PRIs), and the purchase of drugs (AKHS and Mallur). At one block primary health center in Kerala, the local panchayat had provided funds for a generator. Another primary health center in Kerala reported an increase in utilization after the facility had been upgraded with financial support from the block panchayat, which was used to build a new ward and kitchen.

At Mallur, the community uses and pays for services provided by the health cooperative, even though there is a government primary health center less than one mile away where services are provided free of cost. Members of the Cooperative Health Committee felt that the community used the Mallur health center because they perceived it to be of better quality, based on convenience, presence of a doctor, and the availability of drugs. The doctor at the government primary health center is often absent, and the supply of drugs is reported to be inadequate and erratic. In this case, community control has also served to enhance the accountability of health staff to the community.

3.6.2 Equity

Although hard data are lacking, equity of health service delivery is likely to have been enhanced at both Mallur and Kerala, since the local institutions represent a cross section of the community in terms of gender, caste, and class, which increases the likelihood that the needs of all segments of the community are considered. In contrast, members of the sector committees at AKHS are dominated by Ismailis. A recent review of the health project noted that utilization by non-Ismailis was low in relation to their size in the community, while utilization by Ismailis was high relative to their size. It would appear that the community perceives the project to be primarily run by Ismailis and for Ismailis.

In addition, several of the local organizations appear to have successfully tapped contributions from the community while at the same time protecting the poor. The Cooperative Health Committee at Mallur and the sector committees at AKHS are responsible for identifying the poor, who are either fully exempt from charges or receive subsidized care. They appear to find the task of means testing fairly easy since community members are largely known to them.

3.6.3 Efficiency and Financial Soundness

Community involvement has apparently helped to keep costs low. Most of the members of the local institutions serve on a voluntary basis. Local involvement has also led to increased community contributions for health (in the cases of AKHS, Mallur and PRIs), which has improved the financial soundness of health services. In the case of the public health facilities under the control of the PRIs in Kerala, community contributions (in the form of taxes) have been used to supplement shortfalls in non-salary recurrent expenditures, such as fuel and maintenance. At AKHS, revenues raised by sector committees are currently covering between 50 percent to 70 percent of sector costs.

Since responsibilities for maintenance of buildings has been given to PRIs, it has been noted that the maintenance work is carried out both faster and at lower cost. Previously, the health department did not have a separate budget for civil works and maintenance, but had to rely instead on the public works department for maintenance work. Since the PRIs have taken control of health services, however, they have been able to hire local workers directly on contract. It has also recently been suggested that PRIs should publicize the unit costs of all construction and maintenance work they undertake via public notices. This should further serve to increase the accountability of public funds, leading to less corruption and leakage.

Not all of the local organizations are financially strong, however. Mallur is forced to keep salaries below the market rate, since the interest generated on their endowment fund has been declining in real terms over the years. As a result, they have been experiencing a high turnover of health staff.

4. Factors Affecting Success or Failure of Community-Controlled Health Financing

The main factor affecting the success or failure of community-controlled financing appears to be the strength of the local group, both in technical and institutional terms. Technical strength includes knowledge of health-related matters, or the ability to access it, as well as skills in management and finance. Institutional strength includes such aspects as whether local groups are representative of the community they serve in terms of caste, class, and religious compositions, the style of governance and the rules and procedures that local institutions have adopted (e.g., how members are selected, their tenure, how often they meet, how decisions are made and whether there are mechanisms in place to ensure accountability to the community they represent).

Other factors that affect community-controlled financing are:

- whether it is part of a broader strategy in local management and control of health care services;
- support received from outside organizations and individuals;
- whether the local group maintains links and coordinates with other local organizations;
- the diversity of funding, including community financing;
- whether other non-health development needs are being addressed; and
- the ability of local groups to adapt to a changing environment.

Each of these factors is examined below, based on the findings from the literature review and the five mini case studies.

4.1 Strength of Local Institutions

4.1.1 Technical Capacity

Local institutions need to have either in-house technical expertise or be able to access it from the outside as required. The local groups studied in this review tended to have more expertise in health than in management. In some cases, lack of management skills has affected financial performance.

The Mallur Cooperative Health Committee, the Jaipur Hospital Committee and the district health committee in West Bengal all have in-house health expertise, since in all cases, doctors sit on

the committees. RMS, Aga Khan Health Services, UMBVSP, as well as the eight NGO examples included in the literature review, all receive technical support from NGOs. These latter groups also receive some management support from the NGOs, depending on the degree to which management responsibilities have been devolved. However, none had received training in management. Lack of management expertise has especially affected the financial performance at Mallur. Due to poor financial planning, the project has insufficient funds to meet required expenditures.

4.1.2 Institutional Capacity and Good Governance

With respect to institutional strength, local groups that were representative of the community they served in terms of gender, class, caste, or religious affiliation, and had a democratic style of governance, were generally more successful then those that were not. Members of the local structures under UMBVSP are drawn largely from the scheduled castes and from lower class Muslims—the same section of the community that they targeted for health and other development activities. In the case of the PRIs in Kerala, compulsory reservation of seats for women and those from Scheduled Castes and Scheduled Tribes has ensured that these sections of the community are adequately represented on these bodies.

In contrast, sector and zonal-level committees under AKHS are dominated by one religious group, the Ismailis, who make up approximately 70 percent of all committee members but only 19 percent of the target population. As a result, the community perceived that the health services were run by Ismailis, primarily for Ismailis. Utilization of health services by non-Ismailis is low relative to their size in the catchment population. On the other hand, it could be argued that having homogenous representation (in terms of caste, class, and religion) could enhance the cohesiveness of the local management structures and actually facilitate the functioning of the group. However, there does not seem to be any indication that this is true in the case of AKHS.

The style of governance, including the manner in which members are selected, the length of their tenure, how often they meet, the manner in which decisions are made, and the mechanisms in place to ensure local accountability all influence the strength and viability of the local institution in the long run. The manner in which PRI representatives are selected is the most democratic of all the selection procedures adopted by the local institutions among the cases studied. PRI representatives are the only ones that are elected by the public. In the four other examples, members are nominated to serve, usually by other committee members, which can create a system of favoritism and patronage. However, this is minimized to some extent by the fact that all local groups have a fixed tenure for committee membership, thus ensuring that members do not retain power indefinitely. At Mallur, however, in the early stages of the health cooperative, some members served several terms in a row.

Group dynamics and the way decisions are made also influence institutional strength. This is an area that needs strengthening in all of the local groups with the possible exception of the PRIs. Inevitably, a few members (typically the better educated and more wealthy) tend to dominate committee meetings. Nonetheless, good strong leadership seems to be important at least in the early stages, as shown in the case of Mallur. Two community members took a leading role in the cooperative's affairs in the initial stages, so much so that they were termed "benevolent dictators." However, development of a second tier of leadership, as occurred in Mallur, is then crucial to avoid over-dependence on a few people.

A final aspect of good governance is maintenance of accountability to the community served. Mallur (and presumably also UMBVSP since it is also governed by the Indian Registered Society Act) holds an annual general meeting to which the public is invited. This provides an opportunity for

the public to raise questions and to make demands. PRIs are required to hold a gram sabha meeting (made up of all people registered to vote) at least every three months. Since the PRIs have taken over many of the roles and responsibilities previously undertaken by the administration (government), local accountability has improved, largely because the PRIs are closer to the community. PRIs may soon be required to publicly announce the costs of all public works commissioned by them, which should minimize leakage and further increase accountability.

4.2 Financial Control as Part of a Broader Strategy in Local Management and Control of Health Care Services

The evidence suggests that financial control in the absence of management responsibilities will be ineffective in the long run. Financial devolution has to be accompanied by devolution of planning, management and administrative responsibilities. In many of the examples of community-controlled health financing, financial and other management responsibilities were or are being devolved gradually as local capacity was strengthened. Both the Cooperative Health Committee at Mallur and the UMBVSP Society have total responsibility for the management and implementation of health care services.

In the case of the PRIs in Kerala, however, management responsibilities are still partial. PRIs have responsibility for managing the non-salary recurrent budget with the exception of drugs. However, the government administration to date has been reluctant to hand over this authority to them. In addition, at present the PHC doctor reports to both the district medical officer and to the panchayat. This partial control has resulted in some confusion as to who is responsible for what. However, it should be stressed that the transfer of power to PRIs is still underway.

The objective at AKHS is to gradually hand over responsibilities to the communities as sector committees gain strength and capacity. At present, however, the committees have very limited financial and other management responsibilities.

4.3 Support Received from Outside Organizations and Individuals

The ability of the local structures to access external resources (both expertise and funding) on an ongoing basis seems to affect their success. The importance of access to technical expertise—both health and management related—has already been mentioned. Most of the local groups studied receive this support from external NGOs, and in the case of Mallur, from a medical college. The ability to tap external sources of funds also appears crucial. Mallur was the only organization that did not receive funding from outside sources; instead, they rely completely on community financing. Community-generated revenue is insufficient to meet all of Mallur Project's costs. In many cases, complete reliance on community-generated finance may not be feasible in the long run.

Both Action for Welfare and Awakening in Rural Environment (AWARE) and AKHS aim to set up fully autonomous local institutions. These organizations hand over authority to local communities in a phased manner, finally withdrawing completely when the local groups are capable of taking full responsibility. Though AWARE claims to have established many such local institutions, no mention is made in the literature as to whether they receive support on an ongoing basis from external sources, nor is it mentioned how the institutions are now functioning. AKHS also apparently has not planned for ongoing support to the local groups it sets up. Such support does not

necessarily have to come from the NGO itself, but can come, for example, from the government, other local NGOs or even individuals.

4.4 Links with Other Local Organizations

It is important that the local institutions maintain contact with other local organizations, such as panchayats, mahila mandals (women's organizations) and the district health administration. This coordination enhances their status and standing in the community, but also leads to more efficient operations. For example, the Mallur committee coordinates with the local government primary health center for child immunization, ante-natal care and family planning activities. Coordination also leads to a more integrated effort in development; for example, if a local group that is active only in the health sector co-ordinates with one working in education.

Mallur, RMS and UMBVSP and AKHS all mention that they maintain contact with local groups. In some cases, this is made easier since some persons are members of several local organizations. For example, the local panchayat representative is also a member of the village committee set up by RMS.

4.5 Diversity of Funding, Including Community Financing

It is logical that a local group that accesses multiple sources of funding rather than relying on one source will be financially more secure. The source and type of funding also affect financial strength; some sources are more stable and reliable, while others may afford greater flexibility of use. For example, donor (and also some government) support tends to be project-specific, that is, funds are tied to specific activities, and support is limited to a specific time period. Donors rarely provide support for "core" program costs. In contrast, community-generated funds are more flexible, since they can be used at the discretion of the local group to meet local priorities. However, as mentioned above, community financing as a sole source of funding is often not sufficient to cover all program costs.

The majority of local institutions examined tap both community contributions and either donor or government funds. The one exception is the Mallur Health Cooperative, which relies solely on community funds. Mallur, however, is currently facing a financing crisis since community funds cannot cover its costs.

4.6 Responding to Other (Non-Health) Development Needs of the Community

A community group may not have local credibility if it addresses health needs before other development needs are addressed, either directly by them or another organization. Typically, health tends to be of lower priority to the community than the improvement of economic opportunities. Three of the examples in the cases studies (UMBVSP, Mallur, and RMS) and many of the NGO examples included in the literature review addressed economic needs before health and other social needs.

4.7 Ability to Adapt to a Changing Environment

A local group needs to be able to adapt both in programmatic and management terms as the environment changes. For example, community action started in Mallur with the establishment of the dairy cooperative. The cooperative then took on responsibility for providing health care services. In the beginning health activities were financed and managed directly by the cooperative. However, as the dairy cooperative diversified and expanded its economic and social activities, it set up separate management structures for each activity, and also changed the means of financing health activities.

5. Implications of Study Findings for the WACH Project

This review shows that community control of health financing is fairly widespread in India. In many cases, local communities, often aided by NGOs, have taken the initiative to control health financing. The scope and degree of control, however, varies enormously. In some cases, local communities have sole responsibility for raising and managing funds, and in other cases, responsibility is limited to collecting community contributions, or paying certain bills. Success with community-controlled financing has been mixed, and is influenced by a number of factors, especially the technical and management capacity of the local group. The study suggests that, when established and supported correctly, community-controlled financing can have a positive impact on quality of care, equity, efficiency and financial soundness. It also suggests that, when financing is part of a broader strategy of local management and control, community-controlled financing can lead to empowerment of communities. In addition, community control can contribute to greater financial sustainability, especially when community funds are tapped.

It is recommended that community-controlled health financing be established under the WACH Project as part of a broader strategy of local management and control. However, valuable lessons should be drawn from the experiences reviewed in this study concerning how and how not to go about establishing community control. Based on these lessons, the following recommendations are made:

1. Support a Number of Different Models of Community Controlled Health Financing

The WACH Project could support a number of different models of community-controlled health financing, using different community structures with differing financing powers. Either existing community structures could be utilized (such as mahila mandals, economic cooperatives, PRIs, etc.) or a new structure could be created, such as village health committees or societies. This would depend on the presence of local groups, and if it would be appropriate for them to take on further responsibilities.

In many ways, PRIs offer the best option for promoting community control, since they are legal bodies that already have significant power. However, their strength in Madhya Pradesh is unknown. Their capacity in the state would have to be assessed, and the feasibility of supporting them in the context of the WACH Project investigated. For example, PRIs are not able to receive donor funds directly, but they are entitled to register an autonomous society through which donor funds could be channeled. A block panchayat in Kottayam district in Kerala has registered a society for this purpose and it appears to be operating very successfully.

2. Provide Inputs to Build Capacity of Local Institutions

Significant inputs should be provided to build capacity and strengthen local institutions. This includes helping to establish the rules and environment for good governance, such as ensuring that members are selected in a fair way, that tenure is for a fixed period, that they meet regularly, and that mechanisms are in place to ensure local accountability. Institutional strengthening will also require

qualitative inputs, such as team building efforts and promotion of good group dynamics, as well as more technical aspects, such as development of management and health skills. Institutional strengthening would need to be viewed as an ongoing process. One way would be to view community control as a continuum, with authority being handed over gradually as the capacity of local groups is strengthened.

3. Ensure That Other Development Needs Are Being Met

Before introducing community-controlled health financing under WACH Project, an assessment should be undertaken as to whether other development needs, apart from health, are being met. If they are not, it may be difficult to establish community control of health financing since health will be perceived as a relatively lower priority by the community.

4. Involve Local Communities in the Project from the Beginning

Local communities should be involved in project planning, including the design of financing strategies. This will increase their commitment to community control.

5. Provide Support to the Establishment of Community Financing

The project should include efforts to mobilize community resources, such as user charges, pre-payment schemes and revolving drug funds. The literature and case study examples have shown that significant resources can be raised in this way, while still protecting the poor. Moreover, such funds can be used in a more flexible way to meet priorities determined by the community. Local groups should be assisted to design and implement community financing to the level that communities can afford. Mechanisms should be put in place to ensure that the poor are not excluded from services because of their inability to pay.

6. Promote Links between the Local Institutions and Other Local Groups

The project should ensure that local institutions involved forge links with other community groups, as well as with local government health services, so that health and other social services in a particular locality are developed in a coordinated manner.

7. Ensure That the Local Institutions Have Access to Technical and Other Expertise on an Ongoing Basis

Long-term support to the local institutions, both technical and financial, should be ensured to enhance the likelihood of success of community-controlled health financing. This support can be provided by NGOs, academic institutions, donors and others.

Annex A. Guidelines for Mini Case Studies and Literature Review

Background

1. Describe the constituency served (location [e.g., rural/urban]), size, caste, socioeconomic composition (e.g., whether own land, occupation, ownership of other assets).

2. Describe the services provided:

    - Health
        - hospital/outreach
        - curative/preventive/promotive
        - services (MCH, family planning, etc.)
    - Other social services (education, water, sanitation, etc.)

3. When was community control of finance initiated?

4. Who initiated community control and how (e.g., government, community, NGO)?

Local Group/Structure

1. Describe the local group or structure that has financial control (e.g., village committee, *panchayat* body, cooperative, women's group, etc.)

2. Describe its composition (gender, socioeconomic class, caste, political affiliation if any, representation by technical officer (e.g., doctor, teacher) or district administrator

3. How are members/representatives selected to serve on the local group? For example, is it by appointment or election? If by election, who is eligible to vote?

4. What is the period of representation? Have there been changes in representation since local financial control has been in operation? If there have been changes, are there any perceptible differences before and after the changes?

5. Do different members have specific roles and responsibilities?

6. How does the local group function? How often do they meet, how are decisions made (by decree, by vote, or through consensus)?

7. What is the relationship between the local group and other organizations (e.g., panchayat body, district administration, NGO or other local groups such as *mahila mandal*)?

Funding Sources and Financial Control

1. What are the sources and levels of funding for health/social services that the local group controls? Briefly examine its financial history.

2. Do particular funding sources support specific services or expenditure items?

3. What is the legal framework or rules that govern the receipt of funds by the local group?

4. Describe financial management procedures:

   - financial planning and budgeting
   - accounting and record keeping
   - procedures for financial control on use of the funds

5. Has the local group received any training in financial management and accounting?

6. How are decisions made regarding the use of funds?

Community-Generated Funds

If funds are generated from the community:

1. Describe the method of community financing (user fees, pre-payment, other fund raising efforts).

2. Level of funds generated (examine trends over time).

3. Do community funds support specific health costs (or other social services)?

   - how community financing designed, exemptions if any (how is means testing undertaken)?
   - community perceptions of contributing towards health/social service costs
   - impact on utilization of services or quality of care (if possible)

Success of Community Control

In terms of:

- How local structure working
- Utilization of service
- Quality of service
- Efficiency (cost, waste, use of staff)

Annex B. Five Mini Case Studies

- The Mallur Health Cooperative
- Sidhpur Health Project, Aga Khan Health Service
- Rangabelia *Mahila Samiti*
- Urmul *Marusthali Bunker Vikas Samiti*, Phalodi
- *Panchayati Raj* Institutions, Kerala

The Mallur Health Cooperative

Introduction

In Mallur, a rural village in Karnataka state, a local health cooperative provides health care to a population of 7,000. Health activities were started by the dairy cooperative, and they were financed initially from an earmarked tax on each liter of milk produced. At present, health activities are planned and managed by a separate committee of nine persons, who are nominated to serve on the committee on a voluntary basis. The committee has total control of funds and their use. For example, it has the authority to decide the method and level of health staff remuneration and fee levels, as well as the health activities to be supported.

This case study documents the development of the Mallur Health Cooperative and their experiences to date with local management and financing of health care. In particular it examines the functioning of the health committee, which has responsibility for and control of health services and their financing. An attempt is made to extrapolate the factors that have affected both the success and failure of different aspects of community control.

Background

History

The Mallur health project was established in 1973 by the local dairy cooperative. Two persons were largely responsible for this: the then-president of the cooperative and a local member of the legislative assembly. The former, in particular, played an important role in the overall economic and social development of the village. He helped establish dairy farming as the main economic activity in the area by lending money to farmers for the purchase of milch animals, and he encouraged the formation of the cooperative to enable the collective purchase of fodder and sharing of milk sales. He then helped the village to diversify its economic base by taking up sericulture (rearing silkworms for their cocoons) activities. Sericulture has now taken over as the most profitable economic activity in the area.

At the start of the health project, the dairy cooperative approached the community medicine department of St. Johns Medical College for technical support. This support continues today. A faculty member from the college sits on the management committee. Almost all the support provided by the college has been in-kind, mostly in the form of clinical inputs. The project site has been used by the medical college for training students. To date the doctors employed by Mallur have been graduates of St. Johns. All newly qualified doctors are required to fulfill a three-year bond of rural service. Since Mallur is one of the designated rural sites, the project is able to hire doctors at below the market rate.

Health services were initially provided from a rented building in the village. A doctor, auxiliary nurse-midwife, and pharmacist-cum laboratory technician were hired to provide basic curative,

preventive, and promotive care. Some outreach care, such as attending deliveries and health education, was also provided.

During the first three years, health services were financed directly from a tax levied on each liter of milk produced. Costs were shared on a declining basis between the Bangalore dairy (which purchased the milk from the Mallur cooperative) and individual milk vendors (members of the Mallur cooperative). In the first year, the Bangalore dairy contributed two *paises*[3] per liter of milk and Mallur dairy members contributed one paise per liter. In the second year, the contribution from Bangalore dairy fell to one paise per liter, while the contribution from the Mallur cooperative increased to two paises per liter. In the third year, the Mallur cooperative took on the full burden of financing.

In addition to revenue from milk sales, revenue was also generated from user charges. Charges were levied for a consultation with the doctor, drugs, and diagnostic tests. The consultation fee was waived for members of the milk cooperative, and they were given a discount on drugs. Fees were totally waived for the poor, persons mainly from the Scheduled Castes and Scheduled Tribes (this is the terminology used by the government of India to classify those from the lower and thus disadvantaged caste groups). In fact, since the start of the project, St. Johns Medical College has provided a lump sum donation each month for the subsidy of persons from these caste groups.

In the fourth year, the Mallur dairy cooperative withdrew from the Bangalore dairy, choosing instead to sell milk at a higher price to the private sector. Around this time, the method of financing health activities also changed. Instead of an earmarked tax on milk sales of individual cooperative members, health services were funded from overall profits generated from milk sales. Approximately five percent of profits were given to the health cooperative. Over the years a considerable surplus was accumulated in this way. In addition to health services, the dairy cooperative began to fund and provide other social services, such as primary education and mahila mandals (women's groups). The dairy cooperative also helped establish sericulture as an additional income-generating activity.

In 1985 separate committees were established to manage individual economic and social activities, namely for health, education and sericulture. A parent body called Gram Bhivruddhi Sangha was formed to oversee the individual projects. This is a registered non-profit body with the status of society. The society gave the health committee funds to build its own health center on land donated by the government. Seed capital was also provided to start a revolving drug fund. An endowment was given to the health committee to meet other operational expenditures. Financing and management of health activities thus became independent of the parent body.

Community Served

Mallur is a rural village located approximately 60 kilometers from Bangalore, the capital of Karnataka state. The population of the village is 7,000. However, the health center serves a catchment area of around 20,000 drawn from six surrounding villages. The population comprises five main castes: Vokkligas represent 60 percent of the population, Kurivas 10 percent, Thigiluru five percent, Naik five percent, and Scheduled Castes and Scheduled Tribes 20 percent.

[3] 100 paises = 1 rupee

The main occupation in the area is sericulture. With the majority of the households in the area now engaged in this activity, dairy farming has become the second most important economic activity. Other villagers work as laborers and petty shopkeepers. As sericulture is a relatively profitable enterprise, the average income is higher in Mallur than in the surrounding areas. It varies from Rs. 5,000 to Rs. 10,000 per month. This relative affluence is reflected in the development of the village. There are large, permanent dwellings; paved roads; and sanitation.

Health Activities and Other Social Services Provided

Outpatient and inpatient care is provided from a three-bed health center. The center is staffed by a doctor, auxiliary nurse-midwife, a pharmacist, and an accountant. Inpatient care is limited to either emergencies, deliveries, or cases requiring observation. Complicated cases are referred to St. Johns or the government hospital in Bangalore. The health center has a laboratory that performs basic urine, blood, and sputum tests.

Some care is also provided on an outreach basis. For example, the doctor makes emergency home visits, and the auxiliary nurse-midwife attends deliveries. Outreach care is provided by the medical interns from St. Johns who each spend up to three months at the project site as part of their medical training. Specialized medical camps, such as gynecology and eye care, are also held by St. Johns on a regular basis.

A maternal and child health (MCH) clinic is held at the center monthly. The auxiliary nurse-midwife from the nearby government primary health center usually attends the MCH clinics. The health center offers immunization in coordination with the government primary health center. The health center receives some supplies free from the government health center, such as contraceptives, vaccines, vitamin A, and iron folate.

Over the past few years, the health center has been experiencing a high turnover of doctors. Recently, there was no doctor for a period of a few months. As mentioned, the health center is able to hire doctors at below market rate since St. Johns Medical College graduates are obliged to fulfill a bond of three years of rural service. However, they can extricate themselves from this commitment by either making a financial payment or enrolling for post-graduate training.

Utilization of the facility appears to be fairly minimal. There have been no inpatients for the last three months. On average the facility sees about 25 outpatients daily. However, this present low utilization rate could partly be influenced by the absence of a doctor.

The Gram Bhivruddi Sangha also provides other social and economic services. These include a primary school, cooperative for the rearing of silkworms, weavers' cooperative, youth club, and women's group that provides training to women in tailoring. Each of these activities is managed by different committees, with some persons sitting on several of the committees.

Sources of Funding, Utilization of Funds, and Financial Status

Sources of Funding

The health project has two main sources of funding: interest earnings and user fees. The endowment provided by the Gram Bhivruddi Sangha in 1984 was invested in fixed deposits. Interest earnings have been used to fund health services. User charges are levied per item of services rendered. For example, Rs. 20 are charged for a consultation with the doctor, drugs are charged at cost plus a 10-percent markup, and charges for laboratory investigations range between Rs. 5 to Rs. 30. In addition, charges are levied for a home visit, attending a delivery, and per inpatient day. Since the funding is now separate from the dairy cooperative, no differentiation is made between members and non-members. Those from the Scheduled Castes and Scheduled Tribes are charged only Rs. 1 for a consultation, and fees are waived for those considered unable to pay. The doctor is responsible for deciding who is eligible to receive free care. Approximately five to six patients a week are given free services. St. Johns Medical College contributes Rs. 250 a month toward health costs for the poor. Additional community contributions are provided on an ad-hoc basis, e.g., food is provided for staff during camps.

The pharmacist is responsible for collecting fees and depositing revenue in the bank on a daily basis.

Utilization of Funds

Interest earnings on fixed deposits are used to pay the salaries of all staff. Drugs are self-financing, i.e., revenue generated from sales is sufficient to replenish stocks. In fact, a small surplus is generated from drug sales. Fee revenue is used for meeting all other operational expenses, e.g., electricity, water, and maintenance of the building.

Financial Status

Total annual expenditure of the health project is approximately Rs. 225,000. Currently, revenue generated from the fixed deposits and user fees is barely sufficient to cover costs. Interest earnings do cover salary costs, however. This is possible only because staff are paid below market rates. The fee revenue and interest earnings together are insufficient to cover costs as well as raise salaries. To supplement the salaries of clinical staff, a financial incentive was recently introduced. The doctor now receives a portion of income on each laboratory test (50 percent of the profit) he performs and for each home visit. The auxiliary nurse-midwife receives Rs. 20 out of a total of Rs. 50 charged for a home delivery. This will compensate staff to some extent. This financing scheme was recently introduced and, therefore, it was too early to assess its impact.

Health Committee: Composition, Role, and Responsibilities

Composition

The health committee is comprised of nine members, including a secretary and treasurer. Committee members include all members of the Gram Bhivruddi Sangha, the health center doctor, and a faculty member from the community health department of St. Johns Medical College. The committee's rules stipulate that there has to be at least one woman on the committee, as well as one member from the disadvantaged groups (Scheduled Castes or Scheduled Tribes). The caste composition of the present committee appears to roughly reflect the overall caste structure of the population. Three members are from Vokkligas, and one member each is from the other caste groups (Kurivas, Thigiluru, Naik, and Scheduled Castes and Scheduled Tribes, respectively).

Members serve on the committee on a voluntary basis. They are nominated by the Gram Bhivruddi Sangha and other health committee members. Their interest in serving the community and capacity to do so in terms of available time are the main criteria for selection. The period of tenureship is three years; however, members often serve several terms. Earlier when the health project was run directly by the dairy cooperative, the president of the cooperative and one or two other members played a dominant role in all matters related to health. Since the death of the founders, the committee appears more democratic as well as more accountable.

The majority of health committee members are engaged in sericulture and/or dairy farming. One member is a shopkeeper. Two main political parties dominate in the area. The political composition of the committee is unknown. The consultant was informed, however, that political pressures have been brought to bear on the functioning of the committee.

Function, Roles, and Responsibilities

The committee meets monthly. The financial position of the health cooperative is reviewed and discussed. Also, the number of patients who have been attended in the past month and the movement of drugs are reviewed. Problems are discussed, and an attempt is made to resolve them.

The Gram Bhivruddi Sangha holds an annual general meeting, to which the entire village is invited. Community members may raise questions regarding the health project. For example, fee levels is a topic commonly raised at the meeting. Questions may also be submitted in writing to the committee at any time of the year, and they are addressed during the monthly meeting. During the last year, 10 such queries were made. For example, a complaint was submitted about blocked drains and another regarding the absence of a doctor at the health center.

Decisions are made by discussion and consensus. Two or three individuals appear to dominate, although this is less the case than in earlier years. The representative from St. Johns appears influential.

Financial Management and Control

The health committee has total control of health funds. It is responsible for sanctioning the monthly budget for drugs, deciding the method of financing, and setting fee levels. It also sanctions repairs to the building and equipment and purchase of new equipment. For example, the committee recently decided to introduce financial incentives for the doctor and auxiliary nurse-midwife as a means to supplement their income.

The president and doctor control the bank account; indeed, both of their signatures are required on checks issued on behalf of the committee. Accounts are audited annually. Committee members receive no formal training in financial planning or management.

Relationship with the Government and Other Local Groups

There is some coordination between the Mallur health center and the government primary health center located just one kilometer away. For example, the government auxiliary nurse-midwife attends the monthly MCH clinic held at the Mallur health center. The Mallur health center provides some data to the government auxiliary nurse-midwife regarding MCH and family planning coverage.

Interactions with other local organizations and government bodies are on an informal basis. For example, the Gram Bhivruddi Sangha recently made a request to the village panchayat for street lighting, and the panchayat requested the society to provide a motor for the bore well.

The health committee maintains contact with the mahila mandal. At present the committee pays the salary of the sewing teacher.

Impact of Community Control

Overall, the impact of community control of health and health funds can be said to have been positive in terms of utilization of services (and, by implication, health status), quality of care, and efficiency of provision. Having said that, the health cooperative is currently facing serious financial constraints.

Although there is a government primary health center close by, residents of Mallur and neighboring villages still use the health center run by the health cooperative despite provision of free services at the government center. Time did not permit a thorough assessment of impact on utilization and health status. However, it would appear that ante-natal coverage has increased as a result of community control, as have the proportion of deliveries attended by a trained person.

Utilization of the Mallur health center as opposed to the nearby government one would indicate that the quality, at least as perceived by users, is higher in the Mallur health center in terms of availability of drugs and a doctor (the presence of a doctor in the government health center appears to be more erratic), convenience of location, and possibly the association with the St. Johns Medical College. It is not possible to comment on technical aspects of quality.

Community control also appears to have had an impact on the efficiency of services. Program costs have been kept low because of the high level of community involvement. For example,

management is undertaken by the committee on a voluntary basis. Other in–kind contributions from the community as well as from St. Johns also serve to keep costs lower. For example, lower staff costs are a direct result of St. Johns' support. At present the utilization rate is not as high as in previous years. This leads to higher cost per contact.

Although the community-controlled project has had a positive impact in the terms described above, it is currently experiencing serious financial problems. Insufficient funds to hire staff at the proper market rate has resulted in high turnover. The value of the fixed deposits has depreciated in real terms over the years. The scope for further raising user fees is limited because current levels are at or close to the maximum considered to be affordable by the community. The cooperative needs to reexamine its funding sources. At a minimum, the corpus fund needs to be increased to yield sufficient interest to cover real staff costs. This could be achieved through a concerted fundraising effort.

Factors Affecting Success/Failure of Community Control

This case study illustrates that the combination of many factors has influenced the relative success of the project, while a few have contributed to certain weaknesses in the project. These factors can be summarized as follows:

1. The fact that the health project was initiated by the community as well as managed by the community is undoubtedly one of the most important factors contributing to its success. This has created a sense of ownership of the society and its activities. This ownership is reflected in a number of ways: utilization of the facility, in–kind contributions from the community in terms of voluntary time devoted by committee members, and provision of food during specialized camps.

2. Dynamic and strong leadership during the early years also appears to have been an important factor. It provided the motivation and direction required in the early stages. In fact, such was the dominance of the founders that they have been described as "benevolent dictators."

3. A second level of leadership was developed that was able to take over after the death of the founders.

4. A strong economic base was created first, and then social needs were addressed. The fact that funding was linked directly to economic activity was also an important factor. This was helped by the uniformity of the economic activity in the village in the early days.

5. The economic base was strengthened and diversified over the years.

6. The home-based nature of work allowed people to devote time to the society.

7. A high status was accorded to serving on the parent body/health committee. Also, there was wide representation on the committee from all sections of the community.

8. As activities of the dairy cooperative increased, individual management structures for the different social and economic activities were created. As a result, the status of the health project did not diminish.

9. Technical support was sought from St. Johns from the beginning.

10. Because of the considerable assets created (buildings, capital, scope, and range of work), the society gained considerable power and standing in the area. As a result, it could not be ignored by other local power structures, e.g., panchayats, and government social services.

11. Financing approaches changed over time to adapt to project needs. However, there is some concern about the recently introduced incentive–related payment to supplement salaries of health staff. Since income is linked directly to volume of service provided, there is an incentive to provide unnecessary care.

Sidhpur Health Project, Aga Khan Health Services

Introduction

The Aga Khan Health Service (AKHS), a private non-profit organization, supports a community-based health project in Sidhpur, Gujarat state. Health services are managed through a multi-tier system of committees, comprised of volunteers. Committees at each level have different planning, management, and financial roles and responsibilities. For example, the Health Sector Management Committee (HSMC), the first tier of management with responsibility for running the health center and outreach services, has the financial powers of deciding the financing methods to employ, setting fee levels, deciding who should be exempted from charges, and paying certain bills and salaries.

This case study examines community control of health financing through the committees. In particular, it looks at the powers that these committees have and their composition and functioning. Impact of community control is also assessed, including the factors that affect this control.

Background

History

The AKHS is an international, non-profit private organization providing health care in areas in the world where there is significant population of Ismailis (a religious sect of Islam). However, health care provision is not restricted to Ismailis but extended to persons of all faiths within the target area. In India, AKHS runs a tertiary hospital in Bombay as well as community-based health care facilities in many parts of the country. In accordance with the Ismaili faith, the organization places great stress on social duty and responsibility. A system of local management has been set up, which comprises a national health board and a network of volunteers.

AKHS has been providing health care in Sidhpur since the late 1980s. The project in its present form was launched in 1994. Prior to this, a skeletal health service existed, comprising basic maternal and child care. A need was felt by the community for a more comprehensive health project. Planning for this commenced in 1991, and the project was jointly undertaken by AKHS and the local community.

During the first phase, discussions were held with a wide range of community representatives, such as religious leaders, elected representatives, district health staff, and other opinion leaders to orient them to the organization's objectives and philosophy and to gather their perceptions regarding community health needs. AKHS stressed from the beginning that the health project would be community owned and run, and that its role would be to support and facilitate the effort. Health

education and awareness-raising around health issues was also undertaken as part of project preparation.

The project area was divided into nine sectors based largely on accessibility and population. Each sector comprises a population of between 3,000 and 5,000. Committees were formed at the village level. Although membership of these committees was open to all community members, the committees were wholly comprised of Ismailis. The committees played an active role during project preparation and planning.

A number of more formal studies were also conducted to inform project planning. They included a socioeconomic profile of the community, a survey of the present status of health services in the area, burden of illness, current levels of health expenditure, and capacity to pay. Much of this information was collected through focus group discussions. These findings were fed back to the communities and used to decide what health services should be provided and their mode of delivery, management, and financing. For example, one finding was the community demand for diagnostic services. Regarding financing, potential sources of funding were explored within the community, particularly sources and levels of community contributions.

Community Served

The project is divided into project and service villages. Project villages refer to those villages where outreach care is provided, while service villages have no outreach but are within five kilometers of the health center they are able to use. At present, there are 23 project villages with a total population of 40,000. Effective coverage increases to 80,000 if the population that uses the health centers is included.

The population is largely rural and agrarian. In terms of religious composition, Hindus form the largest community, 19 percent are Ismaili, and a small percentage are "other Muslims." The Ismailis are relatively wealthier than other sections of the community. For example, a survey by the AKHS found that out of a representative sample population, only 6.4 percent of Ismailis earned below Rs. 1,000 per month, compared to 16.4 percent of non-Ismailis. Similarly, significant differences in education were also noted, where 19.2 percent of Ismailis were illiterate compared to 37.8 percent of non-Ismailis.

Health Activities and Other Social Services Provided

Community-based health services are provided by a cadre of community health volunteers, approximately three for each village. As their title implies, they are unpaid workers, devoting up to 12 hours per week to health duties. They assist the lady health visitor (each sector has one qualified health worker), provide preventive and promotive care, organize health education, and maintain community health records. The majority of community health volunteers are Ismaili.

At the sector level, a health center provides curative and preventive services and is staffed by a lady health visitor. A doctor visits the health center on alternate days. At the beginning, all health centers were in rented buildings. However, gradually all sectors financed the construction of their own health centers. They have a few inpatient beds and a labor room.

The sectors are organized into two zones, each under the supervision of a medical officer and a lady health visitor supervisor. There is no medical facility at the zonal level. Each zone provides planning, management, and technical support to a cluster of sectors. As mentioned, the doctor visits health centers on a rotational basis.

Finally, there is a diagnostic center in Sidhpur town, which has sonography, radiology, and pathology facilities. The center is used by the project villages as well as by private practitioners in the area.

Apart from health services, AKHS also run an environmental sanitation program in Sidhpur. This includes increasing access to and quality of potable water; raising community awareness of issues related to health, water, and sanitation; increasing capacity of the community to manage and sustain inputs; and conducting research to assess impact of interventions.

Sources of Funding, Utilization of Funds, and Financial Status

The project has three main sources of funding: AKHS, local donations, and user fees. AKHS receives project-specific funding from international donors. The Sidhpur project is supported by USAID/New Delhi, through its joint funding scheme. Local communities provide financial donations as well as in-kind contributions. As mentioned, all health centers have been built with community contributions. Most of these contributions have been from the Ismaili community. For example, a recent evaluation found that out of Rs. 500,000 raised by one sector for construction of a health center, only Rs. 10,000 were from the non-Ismaili community.

Charges are levied for registration, doctor's consultation, drugs, and delivery. A charge has also been introduced for immunization, which covers the cost of disposal syringes. Each sector is responsible for setting its own fee levels to ensure that they are locally appropriate and acceptable. As a result, fee levels vary slightly across centers. All centers waive charges for those unable to pay. Both of the visited centers reported that on average they waive fees for only two to three persons per month. They reported that the task of means testing was fairly straightforward since patients are generally known to them.

In addition to user charges, several centers have introduced other community financing schemes under the guidance of AKHS. A community fund has been started at two health centers. This is a pre-payment scheme where households contribute for a package of health benefits, which includes free registration, a discount on delivery, and screening for diabetes and hypertension. The annual fee varies depending on whether payments are made in one, two, or three installments. Other health centers have designed different pre-paid schemes, for example, one for maternal and child health and another for non-communicable diseases, which includes screening for sugar and blood pressure.

The Meloj Health Center has recently begun to tap another source of finance—the local milk cooperative. The milk cooperative has agreed to donate Rs. 30,000 per year for health coverage of its members. This includes free screening for diabetes and hypertension, free doctor consultations, plus discounts for certain services, e.g., delivery and diagnostic tests. This financing idea came from AKHS, but it was pursued and designed by the Health Sector Management Committee (HSMC). The committee proposed that individual dairy farmers make an earmarked contribution per liter of milk produced. However, the cooperative felt it would be administratively easier to make a lump sum contribution.

User fees are levied at the diagnostic center. Since the aim of this facility is to generate revenue to subsidize other health activities, charges are at cost plus 10 percent.

All capital inputs are provided by the community.

Utilization of Funds

AKHS funds are used for meeting development costs (i.e., project start up costs), costs of administration and management, and certain staff costs.

Revenue generated by each sector from the various community financing schemes is used to cover operational costs. Surplus generated by the diagnostic center is used to meet any remaining deficit.

Financial Status

The project places great emphasis on financial sustainability. It is expected that all sources of combined community financing cover at least 15 percent of operational costs in the first year of the project, raising to 60 percent by the third year.

The project has designated each sector as a cost center. Certain costs that are shared between sectors, such as the doctor and project support staff, are apportioned on an equal basis. At any given time, individual sectors are able to track their income, costs and, hence, financial status.

At present, levels of cost recovery vary across the sectors. On average, they recover between 50 percent to 70 percent of costs. The diagnostic center recovers 110 percent of costs. The surplus is used to cross-subsidize the health centers.

Total operational costs of one sector, Meloj, are at present Rs. 90,000. This includes all costs, such as salaries, drugs, and apportioned joint costs. Income from community financing totaled Rs. 45,000. However, cost recovery is expected to increase considerably since the sector received Rs. 30,000 from the milk cooperative this year.

Local Management Structures: Composition, Roles, and Responsibilities

Health services are managed through an extensive system of committees. This includes health sector management committees (HSMCs), zonal management committees (ZMCs), and a project management committee. Another tier of management, the village health committees set up during project planning, has recently been dissolved. It was felt that while useful in the early stages of the project, this level became increasingly redundant as a tool of management. Other existing local structures are utilized if wider community consultation beyond the HSMC is required, for example mahila mandals (women's groups) or *Aganwadis* (a government nursery scheme for pre-school children).

Each committee has a convener (similar to a chairperson) and a secretary. In addition, there are usually five members on the HSMC and eight members on the ZMC. The committees are not registered and, as such, have no legal status. They are governed by AKHS rules and regulations. However, there are plans once the committees are sufficiently strong to register them as autonomous societies.

Committee members are appointed by project staff. The criteria for selection include age, education, experience in working with the community, acceptance by the community, and availability for voluntary work. Tenure on both the health sector and zonal management committees is one year and three years for the project management committees.

Composition

When the committees were first created, all members were Ismailis. Since then, efforts have been made to make them more representative of the communities at large. At present, Ismailis represent roughly 70 percent of committee members at all levels. AKHS has experienced difficulties in recruiting women onto the committees. During the first year of the project, the committees had very few women. However, recently they have redressed the gender imbalance by appointing community health volunteers to serve on the health sector management committees.

During her trip, the consultant met with representatives from two HSMCs. One HSMC had nine members, of which four were women (all community health volunteers) and seven Ismaili. The other committee had eight members, of which four were women (again, all were community health volunteers) and only one non-Ismaili. Occupations of members included a farmer, a shopkeeper, a health worker, a housewife, and a business person.

Function, Roles, and Responsibilities

Health sector management committees are responsible for the day-to-day management of health centers and outreach care. Specific responsibilities include managing and supporting the health staff (lady health visitor, community health volunteer, and doctor) to carry out their duties; identifying and mobilizing local resources; submitting a monthly report of activities and a financial statement; maintaining health, demographic, and service statistics; and assisting in maintaining accounts and stock registers.

Zonal management committees oversee health services for a cluster of sectors. Their role is to provide technical and supervisory support to the sectors. Since the committee is comprised of representatives from a number of sectors, it is able to take a wider perspective on health sector development in the zone. The committee enables sectors to share experiences and exchange ideas.

The project management committee provides strategic and technical guidance. AKHS has conceptualized a continuum of increasing community responsibility in four stages over the life of the project:

1. In the first stage, community involvement is sought in project planning.

2. Once implementation begins, communities take responsibility for the day-to-day management of health services.

3. Committees then take on management responsibilities. At this stage, decisions are jointly made by AKHS and committees.

4. In the final stage, committees are given financial control.

It is the consultant's view that committees are currently between stages two and three in this continuum of local responsibility.

The health sector and zonal management committees meet monthly, while the project management committee meets quarterly. At sector level meetings, members review progress made over the last month, both in terms of the number of patients seen and financial soundness. The convener is responsible for maintaining the management information system and for financial reporting and monitoring.

The committees have received some training. However, AKHS has no fixed schedule of training nor has it ever undertaken a training needs assessment. All new committee members undergo an orientation training. The annual conference is another forum used by AKHS for imparting training.

It was observed that the committees tended to be dominated by the convener and secretary. Community Health Volunteers, in particular, were not vocal, and they seemed to have low awareness of financial matters. Much more effort needs to be directed at strengthening the capacity of individual committee members.

Financial Management and Control

As mentioned, the health sector and zonal management committees have as yet not been given full financial control. There is one bank account for the entire project held at the project level. The convener of the project management committee and the project manager are co-signatories on checks.

The convener of the health sector management committee is responsible for depositing revenue every two weeks in the project's bank account and may request an advance of up to Rs. 500 at this time. The lady health visitor is able to spend up to Rs. 200 without prior permission. For amounts over Rs. 200, the convener's permission is required. The convener can spend up to Rs. 500, above which permission is needed from the project management committee.

AKHS thinks that it is advantageous to have a single bank account since certain costs are joint to the sector, such as the doctor and drugs (which are purchased centrally). It is also easier for purposes of cross-subsidization across centers (i.e., higher performing ones in the future can cross-subsidize lower performing centers).

The financial responsibilities of the health sector management committees include paying electricity and telephone bills, paying the sweepers' salary, buying stationery, administering the lady health visitor's travel allowance, and purchasing emergency medicine. The salaries of the lady health visitor, supervisor, and doctor are paid by the project.

All expenditure vouchers need to be signed by the convener or secretary. The committees are required to submit a financial report every month. This outlines all sources of income (user fee revenue is broken down for each service) and total expenses.

Relationship with Government and Other Local Groups

The committees coordinate with government health workers (auxiliary nurse-midwife and lady health visitor) for immunization and ante-natal care. They also work with the Aganwadi worker for growth monitoring of children. Contact is also maintained with panchayat institutions.

Impact of Community Control

Community control in the Sidhpur Health Project is as yet partial. AKHS continues to play an important role in project management and implementation. Powers are being handed over to communities in phases. As outlined, committees currently have important management and financial responsibilities. Though not complete, this level of control has certainly contributed to the project's impact in terms of increased health service utilization, quality of care, and efficiency.

No epidemics have been reported in the area. There is 100 percent immunization of children. The health centers are well utilized; on average they see between 15 to 25 outpatients a day. As indicated by the level of revenue generated, the diagnostic center is also well utilized.

The project has been very successful with cost recovery. Most centers are already covering between 60 to 70 percent of their operating costs from a variety of community financing strategies. This is well ahead of the set target.

Factors Affecting Success/Failure of Community Control

The following are key factors in determining the success and limitations of community control.

1. The rigorous community assessments undertaken as part of project planning have ensured that health services and their financing are locally appropriate. Moreover, community participation in project planning has ensured that services and financing strategies are appropriate.

2. Community responsibilities in the implementation of health care has served to enhance the community's stake in the project.

3. The Ismaili religion is likely to have been a significant influence on the project's success. Social duty is an important aspect of the Ismaili religion, and this may explain the high level of community voluntary action. The majority of financial donations is from Ismailis. Seventy percent of committee members are Ismaili, while they represent only 17 percent of the project's population. The relative homogeneity of the committees may also contribute to their smooth functioning.

4. On the other hand, dominance of Ismailis may have had a negative impact. The project is largely perceived as an Ismaili-run project. This may deter participation from other groups in other communities or even utilization of health facilities. A recent evaluation of the project found that the poorest members of the communities were not using services.

5. In terms of the continuum of responsibility and control conceived by AKHS, committees currently are between stages two and three (i.e., have responsibility for day-to-day running of health centers and some management responsibilities). Local committees are not yet strong enough to take on more power.

6. The committees are not very democratic. They tend to be dominated by one or two individuals, usually the convener. More support needs to be given to the development of committees. This also affects their functioning.

7. Systems are not in place to permit local autonomy and control. Local bodies must develop management policies and practice manuals on finance, administration, personnel, marketing, strategic planning, quality of service, advocacy, and external relations.

Rangabelia *Mahila Samiti*

Background

Rangabelia *Mahila Samiti* (RMS), an operational wing of the Tagore Society for Rural Development—a voluntary, not-for-profit organization—is located in Rangabelia, an island in the Sundarban area of West Bengal. Since 1977, its women's group has been working for the comprehensive development of rural women. It has made a distinct mark on the changing pattern of economic, social, and cultural status of the women of Rangabelia.

The organization and its women's group wanted to break the vicious cycle of poverty in an extremely poor and geographically handicapped region of the country. It recognized that the poor status of health, education, and other social welfare measurements could not be improved unless women were effectively organized to achieve economic self-reliance. This realization led to the formation of a women's cooperative to focus on different productive activities, such as weaving, tailoring, knitting, fishery, and honey processing.

The cooperative is an instrument for income generation, but the women also use it to address their social problems. RMS's activities include conducting comprehensive training programs for the women twice in a year. The training package primarily focuses on developing skills in different income-generating activities and includes basic training in primary health care (PHC), sanitation, and environmental preservation. RMS also provides preventive and promotive health care to residents of remote islands through 35 village-level female health workers. It conducts awareness campaigns to make women conscious of their rights and responsibilities regarding their health and environment as well as social injustice, domestic violence, and social evils such as the dowry system, and it encourages women to engage in cultural activities.

Starting in three villages, today RMS is active in more than 100 villages across different parts of Sundarban, a series of islands surrounded by a network of saline-water, estuarine rivers. Approximately 80 percent of the population depends on agriculture. Other occupations include wood-cutting, honey-collection, and fishing. Return from farming is extremely low due to salinity in the water, fragmented plots, a dependence on a mono-cropping system and such natural calamities as floods and cyclones.

The parent organization, the Tagore Society, established a health care system for 60 villages that includes a health center with basic curative facilities, a mobile clinic, and 28 outreach clinic points that are visited by the doctors and the paramedics of the health center on a regular basis. RMS supports this system in three ways: (1) creating intensive health awareness and health education among rural women via a group of female health workers, (2) organizing mothers for preventive health care (especially ante-natal checkups) and nutritional care (for severely malnourished children) in the health center, and (3) teaching basic health care skills to the women who come for training in income-generating activities.

Local Management Structure: Composition, Roles, and Responsibilities

The women's group operates under two different structures. The first one is Rangabelia Mahila Industrial Cooperative Society Ltd., which is a registered cooperative with the objective of producing and marketing several industrial goods, such as cotton cloths and processed honey. The benefits of the cooperative are limited to its 300 members, all of whom are women. It is open to women from all levels of the local community, but one needs to buy at least one share worth of Rs. 100 to become a primary member. A 13-member managing committee is responsible for policy and decision making. The committee has a chairperson, secretary, assistant secretary, and treasurer. All committee members are elected on the basis of mutual consensus at the annual general meeting of the society. The office bearers are elected by the committee members through the same process. All of the committee members are women and come from poor or lower middle-class families.

The second structure of the group is RMS itself. The RMS is responsible for carrying out development activities within the community. The structure is less rigidly defined than that of the cooperative society. The apex body (council) consists of 17 members. The composition is different from the cooperative society in two ways: (1) Two male representatives from the parent organization of the Tagore Society are permanent members; one of whom is usually from the accounts section members; (2) There is more representation from village-level workers and participants. Council members are usually selected through discussions and by consensus opinion.

The leaders of the group strive to keep a balance between these two structures and utilize one in the interest of the other. For example, RMS conducts the training, and the cooperative absorbs a section of the trained women at its production center. In the first half of 1997, 40 women were trained in tailoring, weaving, and knitting. Nine women worked in the cooperative's production center. This process ensures some guarantee of placement after training as well as a steady flow of skilled workers at the production center.

It is also worth noting that a core group of leaders has emerged in RMS. This leadership consists of five or six dedicated women from lower middle-class families. The same group is also involved in the management of the cooperative society. This has helped build a smooth interface between the two independent structures. At the same time, it has created a potential source of bias in the system since the members of the cooperative have greater access to the leadership.

RMS has a very good working relationship with the Tagore Society and the representatives of local self-government (panchayat). The main area of operation of RMS extends over three administrative links with the community through hundreds of village groups and 28 zonal committees. Village groups assess the needs of their villages and send plans to the zonal committees. The committees, in turn, decide and convey the needs to RMS and other wings of the Tagore Society. Each committee consists of selected village representatives, community leaders, and panchayat representatives. This is a departure from the earlier practice of RMS when it kept direct and regular contact with the village groups.

Sources of Funding, Financial Status, and Financial Control

Financial Status and Control

The women's cooperative society runs on a self-generated financial base. Over the last 20 years of operation, it has been able to accumulate a sizeable working capital amounting to Rs. 272,300. The major portion of the profits is usually put back into the system. The audited report of the last year (ending March 1996) shows the following financial facts:

Financial Category	In Rupees	
Gross Turnover	Rs. 510,058	
Net Profit	61,296	
Wages	30,000	(approximately)
Authorized Share Capital	50,000	
Share Capital	1,696	
Gross Working Capital	272,300	
Net Working Capital	267,000	(approximately)

The above figures reveal a very sound financial position. As mentioned earlier, the funds are entirely controlled by the managing committee consisting of semi-literate women. The investment and other financial decisions are made by the managing committee at regular monthly meetings. The products are sold by the women at the production center and to other state-level cooperative organizations (e.g., Tantushree). The committee is also responsible for marketing of products.

RMS, on the other hand, depends almost entirely on external funds. However, it has not acquired the legal status to receive funds directly from international donors. Therefore, the funds for RMS are channeled through the Tagore Society, which currently receives funding from such international donor agencies as ICCO (Netherlands), UNICEF, Kyoto Forum, national agencies such as CAPART, and different ministries under the government of India. Usually there is a provision for RMS activities in most of the budgets. RMS can spend up to the limit of this budgetary provision.

Control is exerted through indirect ways. RMS is fully authorized to prepare its own budget. Preparation is on the basis of recommendations and requirements of the village groups and channeled through the zonal committees. The RMS council discusses the needs and accordingly defines its own proposed activities and corresponding fund requirements for a year. The budget is submitted to the Tagore Society. The general management board of the Tagore Society, which has two representatives from the RMS, negotiates and approves the budget. Due to a strong presence of the women's group in general project activities, the negotiation usually goes in favor of RMS. Once approved, RMS gets full sanction to utilize the funds according to the proposed activities. RMS uses its own monitoring mechanism to control the cost. Since none of the council members is professionally trained in financial management and accounting, a professional accountant has been hired to keep the records and to help in financial planning.

The major advantage of this type of indirect control is that the women workers are not required to come directly under donors' financial scrutiny which, at times, demands substantial time and effort

from the recipient organization. The major drawback, however, is the potential neglect of the sustainability of the programs (and thus internal resource generation) due to the financial dependence on the parent body.

Sources of Funds

The generation of funds from community sources is highly successful in the case of the cooperative society. The society generates funds through paid membership and the sale of produced goods to the community. Funds generated through shareholding are still insignificant. Sale proceeds, on the other hand, represent almost all of total income earned from its productive activities. The level of funds generated from the sale of some major items is given below. (source: Audited financial statements, Rangabelia Mahila Industrial Cooperative Society).

Goods	Income (in Rupees)		
	1993–94	1994–95	1995–96
Garments	Rs 89,274	Rs 116,635	Rs 41,762
Looms	55,278	58,700	53,977
Honey	8,946	11,628	3,120
Fishery products	1,121	1,148	4,445
Source: Audited financial statements, Rangabelia Mahila Industrial Cooperative Society			

The data show an interesting trend. The major share of the cooperative's income comes from its garment section. The income was much higher in 1993–1994 and 1994–1995 in comparison to 1995–1996. This is because in the first two reference periods, RMS had a marketing contract with Tantushree, one of the biggest state cooperatives in the garment business. RMS received bulk orders from Tantushree during this period. This external marketing link received a severe jolt in 1995–1996 when RMS found it difficult to cope with Tantushree's specifications and thus reduced the supply drastically. The issue is whether RMS can grow without a substantial external marketing link. It seems that the present level of local demand can only help to sustain a moderate growth path.

RMS, as mentioned earlier, depends almost entirely on external support. It generates a moderate amount of funds from three sources: (1) rental income from hostel/guest houses, (2) donations for special events such as annual conferences, and (3) leasing out equipment (e.g., amplifier) to local clubs. Income generated from these sources does not add up to even five percent of its recurring cost.

There are at least two potential sources of revenue for RMS: (1) a share of revenue earned by The Tagore Society through user charges for health care activities and (2) user charges for training provided by RMS. The Tagore Society generates approximately Rs. 400,000 through various charges for health care services provided at the main centers and at the outreach clinics. Since RMS contributes directly to the generation of demand for maternal and child health care through awareness campaigns and referral services, a part of the generated funds may be attributed to RMS.

The training programs are fully subsidized by the government of India; hence, there is no incentive to charge additional user fees for this purpose. However, RMS is currently considering introducing a lump-sum training fee for this purpose.

RMS also attempts to help poor women generate income through a savings scheme. Under this scheme, women keep their savings with the local bank, and RMS acts as a catalyst in this process. However, this scheme has not been successful due to incompatible banking practices.

Impact of Community Control

The approach of the women's group is often referred to as an innovative model of women's empowerment through the community's involvement and control. The experiment's emphasis is on economic improvement through market-oriented activities, coupled with a concentrated drive to address the health and education needs of rural women. The organizational structure and its link with the community, established 20 years ago, has remained intact.

The sustainability issue has not been resolved. The present women leaders are those who were actively involved in starting the experiment. The second generation of leadership is yet to be developed. Given the dynamic changes now underway in the rural societal structure, it is very difficult to perceive whether and how younger women will balance economic considerations and a holistic approach of women's development.

RMS contributes indirectly but strongly to the improvement in women's health status. Its major success lies in the perceivable change in knowledge and health-seeking behaviors of rural women. It has been successful in making people understand the importance of safe drinking water. This is manifested in the dramatic reduction of water-borne diseases over the last two decades. One study showed that the incidence of water-borne diseases among children fell sharply from about 65 percent in 1978 to only about 12 percent in 1992 (Kanjilal, B. and D. Sarker. "A New Design for Comprehensive Rural Development" in Dash and Subhudi (ed.). 1996. New Delhi: Commonwealth Publishers).

The comprehensive training package offered by RMS tries to make a woman skilled and knowledgeable in every sphere of her life. Therefore, a woman receiving training in weaving is also required to take a few lessons in basic health care. The demand for this training program is increasing. According to RMS officials, they receive 100 to 125 applications for this program. Only 40 are usually selected. Placement or scope of self-employment is a major issue for the sustainability of this type of training program. It was found that a high percentage of women (35 to 40 percent) still remained unemployed after the training due to a lack of fixed capital. This will remain a major issue against sustainability, if the trend continues.

Urmul *Marusthali Bunker Vikas Samiti*, Phalodi

Introduction and Background

During the terrible drought of 1984–1987, five weavers left their villages and went to Lunkaransar (Bikaner district, Rajasthan) in search of livelihood. They got employment with Urmul Trust under the guidance of Mr. Sanjay Ghosh. Soon they became dissatisfied with the circumstances and came back to Phalodi (Jodhpur district, Rajasthan) where they organized fellow weavers and undertook the tasks of production and marketing. Through their hard work, they achieved a profit of 1 lakh[4] in the very first year (1987–1988). The profit increased to 2 lakhs in 1988–1989 and to around 4 lakhs in 1989–1990, thus attaining self-sustainability. Given this background, the weavers established themselves as a legal entity in the form of a society (registered under the Societies Registration Act, 581-G) in January 1991.

The NGO now operates in 90 villages in the Jodhpur and Jaisalmer districts of Rajasthan. It targets the exploited sections of the society in the area (Scheduled Castes, namely *Meghwal*s), specifically women and children. The districts lie in the heart of the Thar desert. The rural population of Jaisalmer is 290,917, of which the Scheduled Castes comprise 14.55 percent. The literacy rate is 30.5 percent. The rural population in Jodhpur district is 1,388,933, of which the Scheduled Castes comprise 15.32 percent of the population and the literacy rate is 40.69 percent. The target population is rural, and its chief occupation is weaving. Some of the population also own land and livestock.

The activities undertaken by the NGO include forming men's and women's organizations, educational tours for women and children, fairs for children, and instruction in education, health, agriculture, income generation (weaving and tailoring), provision of safe drinking water, awareness of the environment, and struggle against social evils.

Although the NGO was established as a sister concern of Urmul Trust, Bikaner, it functions independently and is a separate legal entity. The Urmul Trust is simply a coordinating agency of similar organizations in and around Bikaner.

The NGO is governed by a 12-member managing board, including the chief executive secretary (*Ramchandraji*) who is elected by the council of weavers. The council members of the NGO comprise 160 weavers from 10 villages. Day-to-day operations are managed by the principal officers. There is an income-generation coordinator who supervises the production coordinator and design coordinator. There is also a development coordinator who supervises the coordinators for women's development and integrated development. Another coordinator is responsible for accounts and administration.

[4] One lakh = Rs. 100,000

Health Activities and Other Services Provided

Included under Integrated Development, coordinated by Mr. Adarsh Kumar, are the following health activities:

- A Referral and Medical Reimbursement Program for complicated deliveries and emergencies. Patients are accompanied by village workers, who are employees of the NGO, to district hospitals or medical college hospitals. In 1996–1997, 31 such cases were successfully handled. For the purpose of reimbursement, patients are categorized on a sliding scale on the basis of income and assets. The program is financed by Action Aid, New Delhi.

- A Tuberculosis Program, also supported by Action Aid, New Delhi, identifies tuberculosis patients through women's groups and village committees. Village workers accompany the patients for treatment. The medical expenses are reimbursed by the NGO according to the same sliding scale as the Referral and Medical Reimbursement Program. The NGO also distributes tuberculosis drugs, purchased with funds given by Action Aid for the purpose. Currently, 20 tuberculosis patients are being served in eight villages. As a mark of success, eight patients have already been cured under the program.

- An Immunization and Malaria Control Program in which the NGO organizes volunteers and arranges for building space for the government's immunization camps. The program also identifies women and children to be immunized. In 1996–1997, 500 children up to five years were immunized. In the malaria season, village workers take blood samples to government pathology laboratories and also distribute free safety tablets supplied by the government. In 1996, 1,300 slides were collected and tested.

- The Women's Development Program covers health education related specifically to maternity and child health and education of adolescent girls. The program also includes training traditional birth attendants. In 1996–1997, 30 attendants were trained.

Other, non-health activities conducted by the Urmul *Marusthali Bunker Vikas Samiti*, Phalodi are:

- Education: The NGO is implementing the Shikshakarmi Program, funded by the Shikshakarmi Board, Jaipur. It runs 13 Shikshakarmi schools with 1,520 students and 37 teachers. The teachers are trained for 277 days. The program also runs Anganwadi schools, specifically targeting girls. There are 14 such schools. It runs 29 schools under the Non-Formal Education program, funded by Lokjumbish Parishad, Jaipur. All these programs attract a total of 3,007 students, of whom 1,408 are girls (as per 1996–1997 figures). The Shikshakarmi Program is coordinated by Ms. Praneeta Kapoor.

- Women's development: These activities are funded by Action Aid, New Delhi, and OXFAM, Ahmedabad, and they are coordinated by Mrs. Kamla Ranga. The NGO has helped form women's saving groups with contributions from fellow members. Presently there are 20 such groups, involving 300 women. Each member deposits Rs. 10 per month, and the money is deposited in the savings bank account of the group. The NGO also provides matching grants to these groups. At present, the corpus stands at Rs. 60,000 rupees. The money is loaned to members at an interest of two percent per month. The

money is used for meeting the educational expenses of children, health expenses, and repair works. Monthly meetings are held to discuss various women-related issues. Training of traditional birth attendants is also conducted under this program. Income-generating activities are also held, whereby 60 women belonging to the lowest socioeconomic group weave woolen fabrics.

- Other developmental activities: These include activities such as the construction of water tanks for a minimum of 10 households with a 15 percent contribution from the community. There is also the Bhawan Nirman Samiti, which constructs school buildings for which the community must make a contribution of Rs. 1,050. All these activities are funded by Lokjumbish Parishad. Other activities include demographic mapping and monitoring child growth, both physical and mental.

The control of finances and operations and their initiation is done collectively by all the participating members, such as women's groups and village committees, in the monthly meetings. There is also a yearly review in the annual general meetings.

Local Management Structure

The NGO functions through a network of grassroots organizations. It has 20 women's groups and a village committee in each of the 90 villages served, all coordinated by village workers. Office bearers in each group or committee are elected from among the members annually. The members belong to the target group of low socioeconomic status such as Meghwals, *Bhils*, and lower-class Muslims. These groups and committees meet monthly to review the ongoing activities, prepare future plans, and discuss other relevant issues.

Each of the women's groups and village committees has an eight-member executive committee, which includes the secretary and treasurer. Four of the members of the village committee are women. Everybody is elected on a yearly basis.

At the NGO level, office bearers or officials may be elected from among the fellow members or appointed from outside, but their performance is regularly reviewed. The planning and monitoring process follows the bottom-up approach through the hierarchy.

As the village panchayats and government offices, especially the police, are dominated by *Rajputs* and other upper castes, there exists an antagonistic relationship between the local committees/groups and the state machinery at the local level. Political affiliations cut through the caste lines, and they play only a minor role at the panchayat meetings.

The Decision-Making Process

Two decision-making processes take place simultaneously. The first is concerned with income-generating activities. Annually, the 160-member weavers elect a 12-member managing board. The board acts through the chief executive secretary (who is also a member of the board) and coordinator at the NGO level. The tasks at this level include finalizing orders, sales and collection, and procuring raw material. Annual review, planning, and budgeting are done at the general meeting attended by all the participating weavers and NGO officials, where decisions are made collectively.

For developmental activities, the basic units are the women's groups and village committees. The village worker, representing the NGO, coordinates with these groups/committees in each village. Monthly meetings are held by these groups to review their ongoing activities. There is an annual meeting of all these groups/committees at the NGO level, represented by their respective executive committee members and village workers. It reviews the activities of the previous year and the planning and budgeting for the forthcoming year, which is done collectively.

The coordinators are responsible for arranging the required funds from the funding agencies and other sources. Funds are kept at the NGO level and disbursed per requirements. Decisions regarding spending the money are made at the group/committee level. The respective village worker, acting through the respective coordinators, brings the money from the NGO to the group/committee.

Sources of Funding, Financial Status, and Financial Control

As per the financial statement of 1996–1997, Urmul Trust, Bikaner, provided a total of Rs. 1,967,079 for fixed asset creation and income-generating activities, of which Rs. 1,984,227 was spent. For educational activities, Lokjumbish Parishad and Shikshakarmi Board provide Rs. 705,714 and Rs. 1,003,368, respectively, of which the expenses were Rs. 738,677 and Rs. 780,695, respectively. For women's development and health activities, Action Aid and OXFAM provided Rs. 39,731 and Rs. 556,221, of which Rs. 38,791 and Rs. 541,922 were spent, respectively. Income-generation activities provided a total of Rs. 4,274,829 of which proceeds from sales were Rs. 3,559,363, the rest being generated from community savings and other contributions. The net income from income-generation activities was Rs. 410,000, of which 50 percent was put back into the NGO.

Budgets related to the external funding agencies are finalized in consultation with them. But the budgetary requirements come from local committees/groups and are consolidated at the NGO level. Because of this bottom-up approach, the beneficiaries themselves are the decision makers. Thus, there exists a high level of commitment toward adhering to the budgeted figures.

The NGO follows a Fund Accounting System and accounts are regularly verified through quarterly audits. No proper variance analysis system is employed, but a monthly review of expenses is done in committee/group meetings. There is a detailed review during the annual general meeting.

Although the NGO hired professional accountants, they have been dismissed. Mr. Surajanramji, although not professionally trained, had acquired the necessary skills and is now the coordinator for accounts and administration.

Community-Generated Funds

The sale of high-quality cotton and woolen textiles nationwide and abroad through the decentralized weaving and tailoring process forms the mainstay of the NGO, and 50 percent of the profits thus generated are retained for NGO expenses.

Other than this, there are women's saving groups with contributions from the members. Loans are given from the fund to members for health-related expenses. For delivery and emergency cases, a system exists for reimbursing medical expenses. The same system also exists for treating tuberculosis patients. Funds are provided by Action Aid, but there is no 100 percent reimbursement, which in effect means charging user fees. A differential rate structure exists, and the served community is categorized under A, B, and C on the basis of income and assets owned. Category A has to pay 100 percent of the expenses, B pays 50 percent, and C pays 25 percent.

As the community is involved in all stages of planning, monitoring, and executing the activities along with the village workers, there is a high degree of satisfaction.

Impact of Community Control

The existence of the NGO is merely a legal structure. In reality, it is a conglomeration of rural people exerting their influence through various local bodies that are bound together under the legal entity called Urmul *Marusthali Bunker Vikas Samiti*, Phalodi.

The bottom-up approach of decision making ensures complete community involvement and formation of various forums like women's groups, village committees, and groups of the lowest socioeconomic category, which enables all sections of the target community to participate in their own development. As the beneficiaries are themselves involved in decision making and implementation, there is full utilization of services.

Of the total funds of Rs. 8,646,463 (1996–1997 figures), self-generated funds are Rs. 4,274,329, i.e., approximately 49 percent. With such a high level of financial and operational involvement, people are highly cost conscious.

As far as success in health activities is concerned, penetration of the tuberculosis and malaria programs into the remotest villages has helped in early identification and proper management of these diseases. Availability of trained traditional birth attendants and the referral program have greatly reduced the probability of maternal mortality. This is evident from the greater community involvement in and satisfaction with these programs.

The community has come up with a few innovative systems for financing and control. It has developed a scientific basis for drawing up the three socioeconomic categories on the basis of a detailed survey of household income and assets owned. This forms the basis of the differential rate structure for medical reimbursement. The community has also formed savings groups with contributions from fellow members from which members are given recoverable loans with interest. Thus the capital base keeps growing. They have also created a revolving fund with contributions of Rs. 1,000 rupees from each of the 160 member weavers (totaling Rs. 160,000), which is used for purchasing raw materials and preventing stock-out situations.

As the community comprises lower-class people, namely Meghwals, Bhils, and Muslims, they face opposition from panchayats consisting of Rajputs and other upper castes. But, having organized themselves under the NGO, they are now exerting greater influence in panchayat meetings and other fora.

Panchayati Raj Institutions, Kerala

Introduction

The panchayati raj system was formally recognized in the Indian constitution in 1993. Designated as "institutions of self-government," the panchayati raj legislation sets up a three-tier system of panchayats, at village, block, and district levels. The panchayats are self-governing bodies that complement the official government structure. The panchayati seats are filled by direct election every five years, and some seats are reserved for Scheduled Castes and Scheduled Tribes and women.

Panchayats are given the responsibility for preparing development plans and are entrusted with certain functions, including sanitation, water, public health, and family welfare. They have the power to levy certain taxes and receive government grants. Panchayats, therefore, provide an interesting example of community control of health provision and financing.

While the constitutional amendment outlined the broad parameters of the panchayati raj system, it left considerable latitude for state interpretation of the act. As a result, the pace of transfer of powers to local elected bodies and implementation of panchayati raj has differed across the country. Kerala is one of three states that has shown a great commitment to panchayati raj.

Panchayati raj institutions (PRIs) in Kerala have been involved in planning health care under the ninth five-year plan, and since last year they have been entrusted with significant powers for the management of health facilities. This mini case study examines the control that PRIs exert over health care provision in the state, particularly over health financing. The study examines responsibilities of village and block panchayats only, since they are considered to be at a level acceptable to represent the "community."

Background

The *Panchayati Raj* Act was introduced in response to the perceived overcentralization of administrative powers and lack of accountability of bureaucrats. It was felt that local governance would make services locally responsive, as well as more accountable.

The first tier of government is the *gram panchayat*, representing a village or group of villages composed of a population between 4,000 to 7,000 residents. The next level is the block panchayat, typically representing between seven and nine gram panchayats. The third tier at the district level is the Zilla Parishad, representing between 500,000 and 1,200,000 individuals. Gram panchayats are split into wards. A ward comprises all people in the area that are eligible to vote (i.e., that are on the electoral register). On average, a ward comprises 2,000 people.

Panchayati raj in Kerala has been given increased impetus due to two recent policy initiatives: the state decision to allocate 40 percent of resources under the ninth five-year plan to PRIs and the transfer of increased powers this year to PRIs for the day-to-day running of public health services. Each of these policy initiatives is examined.

Planning for the ninth five-year development plan commenced last year. Local planning was undertaken by PRIs. This included assessing local needs for different sectors (such as health, education, and agriculture prioritizing needs) and formulating projects. Project proposals were then supported under the development plan, if they were found to be feasible and acceptable.

Planning was undertaken at the ward level. Separate subcommittees were formed for each sector, resource maps were constructed of the area, and needs assessment undertaken with the use of Participatory Rural Appraisal (PRA) techniques. The process was supported by local NGOs and other volunteers. Training camps and seminars were held on different aspects of local planning. During the consultant's visit, the first installment of the plan's resources was released to PRIs.

Last year, PRIs were given significant management responsibilities for public health facilities. This includes ownership of land and buildings, and some financial and staff management responsibilities. PRIs now administer the state grant for non-salary health expenditures (excluding drugs). This was previously managed by the district medical office. Salaries continue to be paid directly by the state treasury, and responsibility for purchase of drugs remains with the district medical office. PRIs are, however, able to supplement state funds with their own resources; for example, for maintenance of buildings, or purchase of additional drugs. During her visit, the consultant came across a number of initiatives where PRIs had provided substantial additional support from their own resources. This included funds for construction of new wards, provision of an electricity generator, and even non-salary recurrent cost support. Although PRIs do not have the powers to hire, fire, and transfer staff, they do have some powers to discipline staff. They are also responsible for approving staff leave.

The transfer of powers to PRIs has been gradual. As would be expected, district administrators as well as doctors resisted the empowerment of PRIs, perceiving it as a reduction of their own powers. However, doctors are beginning to perceive the benefits of PRI control. For example, at one primary health center visited, the doctor felt that matters such as building maintenance and disbursement of fuel allowance was taking place in a more prompt manner.

Health Activities and Other Social Services Provided

As mentioned, PRIs in Kerala have major responsibilities for health and other social services, such as primary education. The gram panchayat is responsible for helping in national programs, such as the Polio Plus campaign (child immunization), chlorination of water and sanitation. They are also responsible for supervising outreach workers, and for ensuring they undertake field visits. At present, the block panchayat shares responsibility with the district administration for management of the block's primary health center. Health staff are required to report to panchayats on administrative matters and to the district medical office on technical matters.

Some PRIs in the state had taken the initiative to support health care provision, even before the introduction of recent policy reforms. For example, in Khallara block, the PRI has provided significant inputs for development of the primary health center. A hospital development committee has been set up that meets once a month to discuss the center's needs as well as progress made with ongoing activities. The panchayat president is the committee chairperson, and the primary health center doctor is the convener (similar to a chairperson). Other members include elected representatives and local business men. The block panchayat has funded the construction of a new ward, patient waiting area and kitchen.

In Kumarkom block, the block panchayat in collaboration with a local NGO has set up a registered society for integrated rural development. The society has established a number of neighborhood societies through development activities, including health, are planned and implemented. The society is able to tap an array of funding sources, including donor funds. (PRIs are not able to tap donor funds directly. (See section below on Sources of Funding.)

Local Management Structures: Composition, Roles, and Responsibilities

The PRIs themselves are the vehicle by which local control is exerted. As mentioned, they are autonomous institutions of self-government.

Panchayati raj representatives are elected by the public. They usually represent a political party, but they may also stand as independent candidates. The Panchayati Raj Act states that elections be held every five years. In the recent past, however, this has not been strictly adhered to. In Kerala, the last elections were held after a period of seven years. The act states that 30 percent of members must be women, and that at least one seat must be filled by a person from a Scheduled Caste or Scheduled Tribe.

Compulsory reservation on panchayat bodies has ensured that there is adequate representation by women and those from the Scheduled Castes and Scheduled Tribes. For example, at one gram panchayat visited, the president plus three other elected representatives were woman. The representatives included a farmer, mine worker, toddy tapper (local alcohol preparer), and business man.

In Kerala, two political parties hold the majority of panchayat seats, the Communist Party of India (Marxist) (CPM) and Congress. In one panchayat visited, seven seats were held by CPM, one by CPI (Communist Party of India), one by Indian National Congress, and one Congress I, while one representative was independent.

PRIs meet twice monthly. Decisions are largely made on the basis of consensus, usually reached by debate and discussion. If consensus is not reached by this process, then panchayat members are entitled to caste a vote. However, this appears to be rare.

A gram sabha meeting has to be held every three months. Gram sabhas comprise all those in a village who are eligible and registered to vote in panchayat elections.

Sources of Funding, Utilization of Funds, and Financial Status

Sources of funding include government grants (both central and state) and revenue raised by levying local taxes. PRIs are not able to accept funds from external donor organizations.

Government funding is of three main types: allocations made under the five-year plan (as mentioned, 40 percent of allocations under the ninth five-year plan are to be spent through PRIs); allocations from the non-plan revenue account to support recurrent expenditures, usually tied for specific expenditures, such as fuel, and maintenance; and funds under various centrally sponsored

schemes aimed at poverty alleviation, such as Jhowar Rojana (employment), DWACRA (women's development), and IRDP (Integrated Rural Development Program).

Revenue is earned on land and property, and professional, entertainment, establishment and market taxes. Tax revenue is retained by the PRI and used at its discretion. It is not earmarked for specific sectors. Tax revenue can represent as much as 50 percent of the total budget of a gram panchayat.

Plan allocations are given with broad criteria for allocations and expenditures. For example, 30 to 40 percent of total expenditures must be in the social sector, and not more than 30 percent is to be spent on construction, e.g., roads. Fifteen percent has to be spent on development of women and 15 percent on development of Scheduled Caste and Scheduled Tribes Panchayats are required to match plan allocations, either through cash or kind (e.g., voluntary labor).

As an example, the total annual budget last year of Khallara block panchayat was Rs. 10,400,000, and that of the gram panchayat was Rs. 12,900,000.

Thus far, PRIs have not levied charges for public health service for purposes of cost recovery. However, a nominal charge of Rs. 1.50 is currently levied at the block primary health center.

Scope of Financial Control

Ability to Receive Funds

As mentioned, PRIs are able to receive government grants as well as revenue from local taxes. However, they are not permitted to receive funds directly from donors.

Ability to Spend Funds

PRIs have control over government grants and revenue raised from local taxes. They are able to decide how best to spend locally generated revenue. Government grants (at least those on the non-plan revenue side) are usually earmarked for specific expenditures. Therefore, PRIs have less discretion regarding the use of these funds. Since government funding is usually inadequate to meet all requirements; however, tax revenue is often used to meet expenditure deficits. This is done most often for capital expenditures, such as building maintenance or construction.

Other Financing Responsibilities

PRIs in Kerala currently have partial control of public health facilities (up to district level). Management responsibilities are shared with the district health administration. Although the Constitutional Amendment of 1992 stipulates that powers be given to PRIs, in practice the transfer of powers has been gradual. Since last year, PRIs in Kerala have responsibility for the day-to-day running of health facilities. They control funds for staff travel allowances, maintenance of buildings, fuel and diet costs. Responsibility for payment of salaries and purchase of medicine is still with the administrative service.

Involvement in Annual/Long-Term Planning

PRIs participated in development planning for the first time last year. They were required to formulate proposals and budgets for different development activities, including health. They identified safe drinking water and mosquito control as priority needs in the health sector.

Financial Management and Control

The president and secretary of the gram panchayat jointly control the bank account. Plan allocations are to be given in four installments. The first installment has been given against the agreed proposal and budget. The second installment will be released upon request without accounting for how the first installment was spent. However, a social audit is undertaken before the third and fourth installments are released.

Impact of Community Control

There have been discernable improvements in the quality of health care provided since PRIs have taken on greater financing and management responsibility. Funds raised from local tax revenue have been used to supplement shortfalls in state government funding, for example, to maintain health facilities, construct wards and kitchens, and buy equipment. One primary health care doctor noted that such improvements have led to greater utilization of the health facility.

PRI control has also led to greater efficiency of health service provision and administration. Health facility maintenance is now undertaken with greater ease and speed. PRIs are able to hire local contractors to undertake maintenance work. Previously the district medical office had to requisition all maintenance work through the public works department. Budgets for civil maintenance was very low, and there were long delays before the work was undertaken.

Although the primary health care center doctors were at first reluctant to have management and administrative powers handed over to the PRIs, they are now beginning to acknowledge the benefits of this transfer of control. The primary health care doctor at Kumarkom noted that it is now easier to obtain travel and fuel allowances then when control of funds rested with the district medical office. This doctor had also approached the local block panchayat for funds for an emergency light (for use during power cuts) for the health center. Instead of just providing funds for the light, the PRI provided funds for the purchase of a generator.

PRI control has also served to increase local accountability. Responsibility for staff supervision has led to decreased absenteeism. PRIs are required to announce and notify the public of costs of any civic works they undertaken. This decreases opportunities for the misappropriation of public funds.

Factors Affecting Success/Failure of Community Control

In Kerala there has been a long tradition of voluntary local action. The PRI movement has been able to benefit from other successful local initiatives, such as the literacy campaign and the popular science movement. Many other states do not have this tradition of local action, and this may influence success of PRI control.

Early resistance from the district administration and health staff regarding the transfer of powers to PRIs has to be well managed.

Sufficient capacity needs to be developed for PRIs to take on their new role. In Kerala, for example, significant support was provided by the NGO sector during local needs assessment and planning under the five-year development plan.

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